INTAKE FORM

Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Mobile Phone: _____

Email: _____ Occupation: _____

Please take your time in providing the following information. All information provided is confidential.

Briefly describe what concern(s) led to your call: _____

_____

When did this concern start? (e.g.: within the last 30 days/ 6--12 months / 2 years / adolescence / childhood)

_____

What areas of your life have been affected? _____

_____

What effect has this had on your personal/ work relationships? _____

_____

What would you like to accomplish in therapy? Please describe your therapy needs and goals. _____

_____

_____

What significant life changes or stressful events have you experienced recently? _____

_____

_____

Are you currently experiencing significant sadness, grief, depression? Yes ___ No ___

If yes, describe current and previous history/ symptoms/ duration/ intensity/triggers: _____

_____

_____

Are you currently experiencing any significant anxiety, panic, phobia symptoms? Yes ___ No ___

If yes, describe current symptoms/ previous history/ duration/ intensity/ triggers: _____

_____

_____

Please describe any significant losses or trauma history you have experienced: _____

_____

_____

Have you previously participated in any type of therapy, counseling or mental health services? Yes ___ No ___

If yes, please indicate which of the following:

☐ Individual Psychotherapy ☐ Couple Psychotherapy ☐ Family Psychotherapy ☐ Group Psychotherapy

If yes, describe presenting concern/ duration/ outcome: _____

_____

_____

What was most helpful? _____

Least helpful? _____

Have you been prescribed medication at any time for any mental health concerns? Yes ___ No ___

If yes, please note who prescribed/ dates/ medication(s)/ dosage: _____

_____

_____

Any history of inpatient mental health hospitalizations? Yes ___ No ___

If yes, please note facility name/ reason for admission/ treatment dates/ duration/ outcome: _____

_____

_____

Any additional information to include here? _____

_____

_____

Family History

Where were you born? _____ Age immigrated: _____

Languages spoken at home: _____ Cultural Identification: _____

Where did you grow up? (city, suburbs, rural) _____ Frequent moves? _____

Please list parents, siblings, significant immediate family members. Use additional space on the back if needed.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

With whom and where did you live while growing up? _____

_____

Mother's occupation: _____ Father's occupation? _____

In the section below identify any family history of the following concerns/ experiences.
Indicate family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

(circle answers that apply)	Describe/ Additional Information	Family member(s) involved
Alcohol/Substance Abuse		
Anxiety, paranoia, obsessive-compulsive		
Depression, mood disorders		
Domestic abuse (threats, physical, verbal)		
Sexual Abuse		
Family Disruption (separation, divorce, loss)		
Family member deployed in armed services		
Eating Disorders, anorexia, bulimia, obesity		
Poverty, food deprivation		
Sudden loss, death, gun violence		
Mental Illness		
Schizophrenia, psychosis		
Suicide Attempts		
Family member incarcerated		
Homelessness		

Any additional family information to include here? _____

_____

_____

Marital Status:

☐ Single ☐ Never Married ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Partner deceased

Seeking a partner? Yes ___ No ___ Are you currently in a romantic relationship? Yes ___ How long? ____

On a scale of 1-10 (best), how would you rate your relationship? _____

Brief relationship history: _____

_____

_____

If married/ partnered, partner's name and length of this relationship: _____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

Any additional information to include here? _____

_____

_____

Physical Health

How would you describe your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent

Please describe any current health concerns/ diagnoses: _____

_____

Describe your current sleeping habits:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent

How many hours of sleep to you get each night? _____ If you are having problems, in which phase of sleep are you experiencing issues? ☐ Falling asleep ☐ Disrupted sleep ☐ Awakening early ☐ Sleep apnea

How many times per week and what types of exercise do you participate in? _____

Are you currently experiencing any chronic pain? Yes ___ No ___

If yes, please describe duration and treatment: _____

_____

Any current or past alcohol, cigarettes, and/or recreational drug use? Yes ___ No ___

If yes, please describe duration and any concerns about use, misuse, addiction or dependence: _____

_____

Occupational information

What do you enjoy about your work, both inside and outside of home? If retired, what did you enjoy about your work? _____

_____

What do you find particularly stressful about your current or previous work? _____

_____

Hobbies? Interests? What do you do to relax? _____

_____

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief: _____

_____

Referral Source

Medical Provider: _____ Phone: _____

Address: _____City/zip code_____

Insurance Provider: _____ Phone: _____

Friend/Family: _____

Internet Search / Keywords: _____

Website (Feminist Therapy Connection, Psychology Today, Yelp): _____

Other: _____