Intake Form

Full Name:_____ Today's Date:_____

Preferred Name: _____

Date of Birth: _____

Address:_____

_____

Home phone:_____May I leave a message? Yes No

Cell phone:_____May I leave a message? Yes No

Work phone:_____May I leave a message? Yes No

Email: _____May I email you? Yes No
(For appointment scheduling purposes only, as email is not considered a confidential medium of communication).

Type of Insurance for referral purposes: _____

How did you hear about me? _____

Have you ever received any mental health treatment in the past? Was this a positive experience for you?

_____

_____

_____

_____

Please include the names of all previous mental health professionals that you have worked with and approximate dates of care: _____

_____

_____

What is your hope doing our time together? _____

_____

_____

_____

Have you ever mentioned or attempted wanting to end your own life? Yes No

If yes, are you currently suicidal? Yes No

Have you ever been hospitalized for a mental health related condition? Yes No

Do you exercise regularly? Yes No

Do you have any weight loss goals? Yes No

Do you sleep 6 to 8 hours/night? Yes No

Please list your prescription medications and dosage: _____

_____

_____

Any other general health information you would like me to know about? _____

_____

_____

Have you ever experienced any trauma including early childhood trauma, abuse, neglect or the loss of a loved one? If yes, please explain: _____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	

How much are <u>each</u> of the following areas currently a struggle?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Family Conflict	1	2	3	4	5
Social/Romantic Relationships	1	2	3	4	5
School/Work Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Please provide any additional information you would like me to know or would be helpful in better understanding you:

_____

_____

_____

_____

_____

_____