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Psychotherapy and Consulting

INTAKE FORM

- Please print out and complete this form and bring it with you to your first session.
- Also, bring a government issued photo identification to your first session.
- Please provide the following information.
- Information that you provide is confidential.

NAME:

(Last Name)

(First Name)

(Middle Name)

BIRTH DATE:

AGE:

GENDER:

____ / ____ / ____
(Month) (Day) (Year)

Male Female

MARITAL STATUS:

CHILDREN & THEIR AGE:

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Domestic Partner | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Married | <input type="checkbox"/> Widowed |

ADDRESS:

(Street and Number)

(City)

(State)

(Zip Code)

HOME PHONE:

CELL PHONE:

EMAIL:

May I leave a message?

May I leave a message?

May I email you?

Yes No

Yes No

Yes No

What is your preferred method of communication? _____

WERE YOU REFERRED BY SOMEONE? IF SO, WHO?

**HAVE YOU PREVIOUSLY RECEIVED ANY TYPE OF MENTAL HEALTH SERVICES?
(such as: psychological, psychiatric, counseling, etc)**

Yes No

LIST PREVIOUS THERAPISTS (OR DOCTORS) AND TREATMENT RECEIVED:

ARE YOU CURRENTLY PRESCRIBED ANY PSYCHIATRIC MEDICATION:

Yes No

Medication: _____ Dose: _____ Prescriber: _____

Medication: _____ Dose: _____ Prescriber: _____

Medication: _____ Dose: _____ Prescriber: _____

ARE YOU TAKING ANY MEDICATIONS OF ANY KIND? LIST:

ARE YOU TAKING ANY VITAMINS, MINERALS, HERBS ETC? LIST:

GENERAL & MENTAL HEALTH

HOW WOULD YOU RATE YOUR CURRENT PHYSICAL HEALTH:

Poor Unsatisfactory Satisfactory Good Excellent

Please list any physical symptoms and diagnoses:

HOW WOULD YOU RATE YOUR CURRENT COGNITIVE HEALTH:

Poor Unsatisfactory Satisfactory Good Excellent

Please list any physical symptoms and diagnoses:

HOW WOULD YOU RATE YOUR CURRENT EMOTIONAL HEALTH:

Poor Unsatisfactory Satisfactory Good Excellent

Please list any physical symptoms and diagnoses:

HOW WOULD YOU RATE YOUR CURRENT QUALITY OF SLEEP:

Poor Unsatisfactory Satisfactory Good Excellent

Are you experiencing any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Difficulty falling asleep? | <input type="checkbox"/> Nightmares? |
| <input type="checkbox"/> Difficulty staying asleep? | <input type="checkbox"/> Night Terrors? |

HOW WOULD YOU RATE YOUR CURRENT APPETITE:

Poor Unsatisfactory Satisfactory Good Excellent

- | | | |
|--|--|--|
| Any recent weight gain? | Any recent weight loss? | Any GI issues? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

HOW WOULD YOU RATE YOUR CURRENT LIBIDO:

Poor Unsatisfactory Satisfactory Good Excellent

HOW WOULD YOU RATE YOUR CURRENT ATTENTION & CONCENTRATION:

Poor Unsatisfactory Satisfactory Good Excellent

HOW WOULD YOU RATE YOUR CURRENT ABILITY TO BE MINDFUL:

Poor Unsatisfactory Satisfactory Good Excellent

HOW WOULD YOU RATE YOUR CURRENT QUALITY OF SLEEP:

Poor Unsatisfactory Satisfactory Good Excellent

HOW WOULD YOU RATE YOUR ABILITY TO REMAIN PRESENT IN THE MOMENT:

Poor Unsatisfactory Satisfactory Good Excellent

HOW WOULD YOU RATE YOUR ENERGY LEVELS:

Poor Unsatisfactory Satisfactory Good Excellent

WOULD YOU CONSIDER YOURSELF:

Physically restless Uneasy
 Fidgety Without purpose

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING GRIEF, SADNESS, DEPRESSION?

Yes No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING ANXIETY, PANIC ATTACKS, PHOBIAS?

Yes No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING WORRY, RACING THOUGHTS, CONTINUOUS THOUGHTS?

Yes No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING ANY PHYSICAL PAIN?

Yes No

If yes, for how long? _____)

Type and location of pain: _____)

Intensity of pain on scale of 1 to 10: _____)

HOW OFTEN DO YOU EXERCISE?

HOW OFTEN DO YOU MEDITATE?

HOW MANY LITERS OF WATER DO YOU DRINK PER DAY?

HOW OFTEN DO YOU SPEND TIME OUTDOORS?

HOW OFTEN ARE YOU LEARNING OR DOING NEW THINGS?

HOW OFTEN DO YOU USE:

Alcohol?	Cigarettes?	Marijuana?	Recreational drugs of any type?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

How often?	How often?	How often?	If yes, which??
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Do you use any other form of drug to escape or numb emotional pain? _____ If so, which? _____

Yes No

ARE YOU CURRENTLY IN A ROMANTIC RELATIONSHIP? Yes No

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

ARE YOU CURRENTLY EXPERIENCING ANY SIGNIFICANT LIFE SITUATIONS, LIFE CHANGES, OR STRESSORS?

FAMILY MENTAL / EMOTIONAL HEALTH HISTORY

Has anybody in your family experienced any of the following conditions?

Anxiety:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____
Depression:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____
Substance Abuse:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____
Suicide Attempts:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____
Mental Disorder:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____
Dementia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____
Violence:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____

List any other family history:

ADDITIONAL INFORMATION:

HIGHEST EDUCATION LEVEL COMPLETED:

ARE YOU CURRENTLY EMPLOYED?

Yes No

If yes, what is your profession? _____

DO YOU FEEL THAT YOUR CURRENT EMPLOYMENT/ WORK IS REWARDING?

Yes No

ARE YOU A SPIRITUAL OR RELIGIOUS PRACTITIONER?

Spiritual Religious Both None

If yes, please describe your belief, faith, or practices?

WHAT WOULD YOU SAY ARE YOUR STRENGTHS?

WHAT WOULD YOU LIKE TO ACCOMPLISH THROUGH THERAPY?

ADDITIONAL NOTES:
