Intake Form

Please provide the following information and answer the questions below. Please note: This is protected confidential information. Please bring form to your first appointment. If you are unsure, leave the question blank and we will review it during your intake.

Name: ____
(Last) (First) (Middle)

Birth Date:____/____/____Age:______Gender:__________Nickname/Preferred Name: _______________

Marital Status:

☐ Never Married ☐Domestic Partnership ☐Married ☐Separated ☐Divorced ☐Widowed

Address: ____
(Street and Number) (City/State/Zip)

Home Phone: ( )_________________Messages ok? ☐Yes ☐No

Cell/Other Phone: ( ) ________________ Messages ok? ☐Yes ☐No

Email:____May we email you? ☐Yes ☐No

Emergency Contact Name:____________________________________Relationship: _________________

Emergency Contact Number: ( ) ______________

Referred By: ____

Preferred Method of Contact:____

Primary Insurance Carrier

Name of Insurer:____

Insurance ID #: ____________________Group #:_________ Effective Date of Policy:________ Co-pay Amount:______

Guarantor Information / if other than you:

Guarantors First Name:_____________________ M.I.:_____ Last Name:___________________ Date of Birth:________

Relationship to you:__________________ Phone: (______)_______-_______ Email:______________________________

Home Address:___________________________________ City:_____________________ State:____ Zip Code:_______

Social Security Number / required for insurance claim:____

Secondary Insurance Carrier / if applicable

Name of Insurer:____

Insurance ID #: ____________________Group #:_________ Effective Date of Policy:________ Co-pay Amount:______

Guarantor Information / if other than you:

Guarantors First Name:_____________________ M.I.:_____ Last Name:___________________ Date of Birth:________

Relationship to you:__________________ Phone: (______) ______-_______ Email:________________________________

Home Address:____________________________________ City:_____________________ State:____ Zip Code:_______

Social Security Number / required for insurance claim:____

Have you previously received any type of mental health services (therapy, psychiatric care, etc.)?
☐No
☐Yes, previous therapist/psychiatric provider: ____

Are you currently taking any prescribed medication?
☐No
☐Yes, please list: ____

Have you ever been prescribed psychiatric medication?
☐No
☐Yes, please list and include dates:

____

General Health & Mental Health Information:

- How would you rate your current physical health (please circle one):

  Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

____

____

____

- How would you rate your current sleeping habits (please circle one):

  Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

____

____

____

- How many times per week do you generally exercise: _________

What types of exercise do you participate in: ____

- Please list any difficulties you experience with your appetite or eating patterns:

____

- Are you currently experiencing overwhelming sadness, grief, or depression?

☐No
☐Yes, if so, for approximately how long? ______________________________

- Are you currently experiencing anxiety, panic attacks, or have any phobias?

☐No
☐Yes, if so, when did you begin experiencing this? ______________________________

- Are you currently experiencing any chronic pain?

☐No
☐Yes, please describe: ____

- Do you drink alcohol more than once a week? ☐No ☐Yes
- How often do you engage in recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never
- Are you currently in a romantic relationship? ☐No ☐Yes, for how long? _________________

  On a scale of 1--10 (10 being the best), how would you rate your relationship? __________
  What significant life changes or stressful events have you experienced recently:

  ____

  ____

  __

- How long has this been a problem for you?____

- Have you ever considered harming or killing yourself? ☐No ☐Yes
- Are you having current thoughts of hurting yourself or kill yourself? ☐No ☐Yes
- If you are having thoughts of hurting yourself, do you have a plan? ☐No ☐Yes
- Trauma History (sexual, physical, emotional). Please specify:

  ____

  ____

  ____

- Legal History:____

- Developmental History:____

- Level of Education:____

Family Mental Health History:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please Check	List Family Member
Alcohol/Substance Abuse	☐No ☐Yes	
Anxiety	☐No ☐Yes	
Depression	☐No ☐Yes	
Domestic Violence	☐No ☐Yes	
Eating Disorders	☐No ☐Yes	
Obesity	☐No ☐Yes	
Obsessive Compulsive Disorder	☐No ☐Yes	
Schizophrenia	☐No ☐Yes	
Suicide Attempts	☐No ☐Yes	

Additional Information:

- Are you currently employed? ☐No ☐Yes

If yes, what is your current employment situation?

____

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

- Are you currently a student? ☐No ☐Yes

If Yes, where are you enrolled and what degree/program are you pursuing?

____

____

- Do you consider yourself to be spiritual or religious? ☐No ☐Yes, if so, describe your faith or belief:

____

____

- What do you consider to be some of your strengths?

____

____

- What do you consider to be some of your weaknesses?

____

____

- What would you like to accomplish out of your time in therapy services?

____

____

- Do you have any questions?

____

____