

Today's Date: _____

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name _____
(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: ____ Gender: Male Female

Marital Status:

- Never Married Domestic Partnership Married
 Separated Divorced Widowed

Relationship Status:

- Currently in a Relationship Currently not in a Relationship

Please list any Children/Ages: _____

Address: _____
(Street and Number)

(City) (State) (Zip)

Cell Phone: _____ May I leave a Voice Message? Yes No

May I send a Text Message? Yes No

E-mail: _____ May I email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
 Yes, previous therapist/practitioner(s): _____

Are you currently taking any prescription medication?

- Yes
- No

Please list: _____

Have you ever been prescribed psychiatric medication?

- Yes
- No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

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

5. Are you currently experiencing overwhelming sadness, grief, or depression?

- No
- Yes

If yes, for approximately how long? _____

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

- No
- Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? No Yes

9. How often do you engage recreational drug use?
 Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

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

11. What significant life changes or stressful events have you experienced recently:

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.).

	<u>Please Circle</u>	<u>List Family Member</u>
--	----------------------	---------------------------

Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. 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?

2. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. From your perspective only, what do you think the problems and challenging issues are in your relationship and/or marriage? What exactly is "the problem" you wish to make better? Please be as specific as possible.

6. How long have you encountered this problem? When did this problem (or problems), first appear?

7. How have you tried to address this issue? What attempts have you made to make this better?

8. What happens when you try to make improvements? Do things get better? Do they get worse?

9. What outcome are you looking for? What would "successful" therapy look like for you? What do you think has to be "different" for your relationship/marriage to be "different" than it is now?

10. Any other thoughts you wish to add?

Thanks so very much for taking time to fill out this Intake Form! Your personal thoughts and input is so very valuable and important for us to achieve positive results!