INTAKE FORM

Date: ______________ SSN____

Name: ____

Date of Birth:____ Age:__________________

Legal Name, if different?(for insurance purposes)____

Gender Identity:______________________________Pronouns:____________________________________

Sex assigned at birth? (for insurance purposes)____

Address: ____

City: ______________________________State: ____________________________Zip:___________________

Educational Level:____

Marital Status: ____

Home Phone: (___) _____-______ Message OK? ❑ Yes ❑ No

Occupation: ____

Work Phone: (___) _____-______ Message OK? ❑ Yes ❑ No

Employer:____

Other Phone: (___) _____-______ Message OK? ❑ Yes ❑ No E-mail: ______________________________

Emergency Contact: ____

Relationship to you: ___________________ Emergency Contact Home Phone: (____) _______________

Emergency Contact Work Phone: (____)_______________________

Whom were you referred by/ how did you hear about my services?_______________________________

Do you consent to an appointment reminder service? ❑ Yes ❑No

Billing Information

Name: ____

Date of Birth:____ Age:__________________

Address: ____

City: __________________________State:___________________ Zip:_________________________________

Primary subscriber name and Relationship to you:____

Home Phone: (___) _______________ Work Phone (___)_______________

Other Phone: (____)____________________

Occupation: ____

Employer: __________________________________ E-mail:______________________________________

Language spoken at home: ❑ English ❑ Other:____

***Please provide a copy of insurance card if using insurance benefits.**

CONFIDENTIAL HISTORY

Partner/ Marital Status: (Check all that apply.)

❑ Married ❑ Living Together ❑ Never Married ❑ Divorced ❑ Separated ❑ Remarried ❑

Years Married: ________________________

Polyamorous relationship Partner's Name (If Applicable): ___________________________________

If in a polyamorous relationship: how many Partners and Names:_____________________________

If not married, are you currently in a romantic relationship? If yes, for how long?_________________

On a scale of 1 to 10 (10 being excellent, 1 being very poor), how would you rate your current romantic relationship?____

Children:

Name: ____Gender:_______ Age: __________________

Name: ____ Gender:_______ Age: __________________

Name: ____ Gender:_______ Age: __________________

Name: ____Gender:________Age: __________________

With whom were you raised? (Check all that apply.)

❑ Biological Parents ❑ Parents and Step Parent ❑ Foster Parents ❑ Single Parent ❑ Adoptive Parents ❑ Relatives ❑ Institution ❑ Legal Guardian ❑ Other: _________________________________

Medical Conditions or Health Issues____

Current Physician:____ Phone #: (____) ____________

Date and Reason of your last visit:____

When was your last physical?____

Medication: ____

For What Condition: ____

Medication: ____

For What Condition: ____

Please describe other serious illnesses or injuries:

____

____

How would you rate your current physical health on a scale of 1 to 10? (10 being excellent, 1 being very poor):___________

How would you rate your current sleeping habits on a scale of 1 to 10? ______________

Please list any specific sleep problems you are currently experiencing:______________

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

____

Is there a family history of treatment for psychological/psychiatric conditions? ❑ Yes ❑ No
Comments:

Have you had previous counseling or psychotherapy? ❑ Yes ❑ No

With whom and when:____

Are you currently experiencing any overwhelming sadness, grief or depression? If yes, for approximately how
long?____

Have you ever felt suicidal? ❑ Yes ❑No

Have you ever felt homicidal? ❑ Yes ❑No

Have you ever been hospitalized for Suicidal ideation? ❑ Yes ❑No
When?____

Do you feel this way now? ❑ Yes ❑ No Comments: _________________________

Have you ever been hospitalized for homicidal ideation? ❑ Yes ❑No
When?____

Do you feel this way now? ❑ Yes ❑ No Comments: _________________________

Are you currently experiencing anxiety, panic attacks, or have any phobias? ❑ Yes ❑No

If yes, when did you begin experiencing this?___________________________

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

If yes, please describe:______________________________________

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

____

Are you involved in any legal proceedings? ❑ Yes ❑ No Comments: ___________________________

Do you take sleeping pills? ❑ Yes ❑ No What type: ____________________ Frequency:____________

Do you drink alcohol? ❑ Yes ❑ No What type: ____________________ Frequency:________________

Do you use tobacco? ❑ Yes ❑ No What type: ____________________ Frequency:_________________

Do you use other drugs? ❑ Yes ❑ No What type: ____________________ Frequency:______________

Additional Information:

If currently employed, what is your current employment situation?____

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

Do you consider yourself to be spiritual or religious? If yes, please 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 are your main concerns/reasons for seeking treatment?____

____

____

____

____

Please circle the items that cause you the most trouble in you life:

Abuse Addictions Anger Anxiety Apathy Carelessness Doubts Fear Guilt Headaches Health Impulsiveness Inadequacy Indecisive Inferiority Insecurity Irresponsible Loneliness Lustful thoughts Memory Mood swings Obsessive Thoughts Panic Poor concentration Poor decisions Rebellion Rejection Restlessness Sadness Sex Spouse Stress Tardiness Thought Process Underachievement Withdrawn Worry

Please list all family members, including yourself, aunts, uncles, brothers, sister, parents, grandparents and cousins who suffer from the following problems:

Depression____

Alcoholism ____

Drug Abuse ____

Addictions ____

Suicide Attempt/Completion ____

Suicidal Thoughts/Behavior____

Psychiatric Hospitalization____

Psychiatric Medications ____

Manic/Depression ____

Mood Swings ____

Schizophrenia ____

Thought Disorder ____

Developmental Delays ____

Seizures ____

Sleep Disturbance ____

Eating Problems ____

Coordination Problems____

Hearing Problems____

Head Injury ____

Speech Problems ____

Hypoglycemia____

Anxiety ____

Unexplained Lapse in Time ____

Child Abuse ____

Incest ____

Grief Issues ____

Cancer or Other Health Issues ____

ADD or ADHD____

Dyslexia ____

Processing Information Problems ____

Memory Problems ____

Reading Difficulties____