

INTAKE FORM

Date: _____

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 _____