Intake Form

Please fill in the following information as completely as possible. The following information is used to record patient histories, for treatment planning, and for use in measuring change over time. All information is covered by our confidentiality policy (see attached office policies). If additional room is needed to complete this questionnaire, please feel free to write on the back of this form.

Personal Information

Name: _____

DOB: _____ Age: _____ Gender: _____

Where are you from? _____

Where do you currently live, and how long have you lived there? _____

_____

Who do you live with? _____

Name the family members, or those you grew up with, and briefly describe your relationship to each person: ____

_____

_____

_____

_____

How would you describe your childhood? _____

_____

_____

_____

Have you ever lost someone very close to you? _____

_____

Have you ever endured any form of abuse (neglect, emotional, verbal, sexual)? Which types and by whom? _____

_____

_____

_____

Describe your support system: _____

_____

Please describe how your support system does, or does not, meet your current needs: _____

Relationship Status (Circle) : **Single** **Married** **Seperated** **Divorce Partnered/Other**

Sexual Identity (Circle): **Straight** **Gay/Lesbian** **Bisexual** **Questioning** **Trans gender/Sexual**

How do you feel about your current primary relationships? _____

Have you noticed any patterns in the relationships you form with others, be it romantic or for friendship? What patterns can you identify, and how do you feel about those patterns? _____

Important relationships:

Name	Good Parts of Relationship	Bad Parts of Relationship

Present Concerns

Please describe what has happened that has led you to seek counseling now. _____

_____

_____

_____

_____

Please check any of the concerns or symptoms listen below that you are currently experiencing:

☐ Muscle twitches	☐ Wish You Could Go To Sleep and Never Wake Up
☐ Decrease in energy or Fatigue	☐ Impaired Memory (forget things more than usual)
☐ Hyperactivity	☐ Racing Thoughts or Speech
☐ Impulsiveness	☐ Tendency to go off on tangents
☐ Sexual Problems	☐ Difficulty speaking
☐ Restlessness	☐ Racing Heart
☐ Problems at work, school or academics	☐ Anxiety
☐ Over-aggressiveness	☐ Fear of abandonment
☐ Withdrawn from family or friends	☐ Panic Attacks
☐ Stealing or Dishonesty	☐ Excessive Worry
☐ Destructiveness	☐ Flashbacks of Distressing Events
☐ Disorganization	☐ Phobias or Excessive Fears
☐ Trouble with Authority Figures	☐ Afraid of Open Spaces
☐ Breaking Rules, Pushing Limits	☐ Nervousness
☐ Injuring Self (such as cutting, pulling hair, etc.)	☐ Unsure of What is Real
☐ Trouble with Sleep (too much, too little, insomnia, etc.)	☐ Feel Like You are Outside Your Body Watching Self
☐ Anger or Hostility	☐ Sometimes Think You Are Hallucinating
☐ Depressed Mood or lingering sadness	☐ Obsessions, Trouble Getting Thoughts Out of Mind
☐ Crying Spells or Tears Come Easily	☐ Excessive Fears of _____
☐ Emotional Highs	☐ Concerns Others Are Spying or Trying to Poison You
☐ Feeling Guilty	☐ Suicidal Thoughts or Wishes
☐ Helplessness	☐ Murderous Thoughts or Wishes
☐ Hopelessness	☐ Eating Disorder (starving, binging or purging)
☐ Irritability	☐ Emotional eating
☐ Feelings of rejection	☐ Unable to Maintain Normal Weight
☐ Low Self-Esteem	☐ Dissatisfied With Body Shape or Weight
☐ Reduced Interest or Enjoyment in Life	☐ Concern Over Your Use of Alcohol
☐ Noticeable Mood Swings	☐ Concern Over Your Use of Drugs
☐ Difficulty Thinking or Concentrating	☐ Persistent Desire for Alcohol or Drugs
☐ Easily Distracted	☐ Chronic Pain
☐ Difficulty Making Decisions	☐ Medical Conditions:

Check the response which best applies:

My current concerns and symptoms are:

___ The continuation of a long-standing condition
___ A recent worsening of an on-going condition
___ The reoccurrence of a previous condition
___ Significantly different from any previous condition
___ My first occurrence of any condition

My current symptoms developed:

___ Suddenly (over less than 4 weeks)
___ Gradually (over one to several months)
___ Very gradually (over one to several years)

Please rate the overall level of stress that you feel is currently pressing on you, including life changes, work, family, and finances. (Circle appropriate number).

1	2	3	4	5
Minimal		Moderate		Extreme

How are your current concerns or symptoms interfering with your life? (e.g., health, relationships, quality of life) _

_____

_____

_____

Can you identify concerns that have been a constant in your life? If yes, please describe. _____

_____

_____

What are the beliefs you have regarding your *current* concerns? _____

_____

What do you think maintains the problems you experience? _____

_____

What helps? _____

What are some of your strengths? _____

_____

What are your life goals? Who do you share those goals with? _____

_____

What are your goals for therapy?

Work History

Current occupation:

Are you experiencing any concerns due to work?

Medical History

Do you have any allergies? If yes, what are they?

Do you have any illnesses at this time? If yes, what?

Have you ever had surgery? If yes, when, and for what?

How have you been sleeping lately? (e.g., insomnia, interrupted, excessive, average)

How is your appetite lately?

Are you taking any non-psychiatric medications currently? What are they?

Mental Health History

List any family history of mental health problems.

Have you had previous counseling or therapy? If so, when, with whom, and for how long?

Did you receive a diagnosis? Please list if applicable.

Have you ever attempted suicide or been hospitalized for harming yourself? If so, when?_____

_____

_____

Did you find previous experience with therapy helpful? If so, what changes did you notice? _____

_____

_____

_____

What did you like and dislike about working with past therapists, if applicable? _____

_____

_____

Please list any psychiatric medication taken in the past, and how long those medications were used. _____

_____

_____

_____

Drugs and Alcohol

Are you currently using non-prescription drugs or prescription drugs for purpose,s other than medically prescribed? _____

Please list other substances that you use. Include amount and frequency.

Alcohol _____

Heroin _____

Marijuana _____

Psychedelics_____

Caffeine _____

Methamphetamine _____

Tobacco (cigarettes, etc.) _____

Other

List any family history of substance abuse. _____

_____

_____

Activities

What do you do for fun? _____

_____

Do you have any hobbies? _____

_____

Do you exercise? Is so, where, and what do you do? _____

_____

What activities are emotionally draining for you? _____

_____

What activities help energize you or stimulate you mentally? _____

_____

What brings your life happiness and meaning? _____

_____