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INTAKE INFORMATION

Date:_____

Name:_____ Birthdate:_____ Age:_____

Address:_____City/State/Zip_____

Phone: (H):(___)_____Messages OK? ___ (W):(___)_____Messages OK? _____

Cell:(___)_____Messages OK? ___ Which number to you prefer to be reached at? H/W/C

e-mail address: _____ Social Security No. _____

Referred by:_____

Person and number to call in emergency: _____

Current Partner/Marital Status:_____ Years:____ How many previous partners/marriages?_____

Current Partner/Spouse's name: _____ Age:____Occupation:_____

Your Occupation/position:_____ Highest Education attained:_____

Employer and address: _____

Legal concerns/problems:_____

Past counseling/Psychotherapy/Psychiatric Hospitalizations: (use back of page for more than 2)

1) Therapist: _____Phone/Address:_____

Reason/Issues:_____

Was is helpful?:_____# of sessions: _____ Dates:_____to_____

2) Therapist: _____Phone/Address:_____

Reason/Issues:_____

Was is helpful?:_____# of sessions: _____ Dates:_____to_____

Have you ever considered suicide? yes or no Recently? yes or no

Do you engage in any self-harm behaviors? Yes or No What are they? _____

Please describe briefly your reasons for seeking treatment. You may also wish to add to your description any past history that might be helpful to your treatment.

What do you hope to gain from therapy?

If you need more space, please use the back of this form.

Please provide information about your family. Be as complete as possible.

Name	State and City of Residency	Age	If deceased, age & year of death	Marital Status	Occupation	How do you or how did you get along?
Spouse/Partner						
Children						
Others living in household now:						
Mother						
Father						
Step-parents (married to whom?)						
Sisters & brothers (give order of birth)						

Which relatives have (or had) emotional difficulties or psychiatric illnesses, including alcoholism?

Relative	Describe difficulty or illness

If you need more space, please use the back of this form.

When were you last examined by a physician? _____ Reason: _____

Name of Physician: _____ Phone: _____

Name of Psychiatrist: _____ Phone: _____

List current major health problems: _____

_____

List previous surgeries, medical treatments, crises, handicaps or hospitalizations:

_____

_____

_____

List all medications you are now taking (with dosage and reason):

_____

_____

Past/present drug/alcohol use:_____

_____

_____

Please mark all of the following that apply

Physical Symptoms

__ Insomnia	__ Tightness In Chest	__ Dry Mouth
__ Tired	__ Dizziness or Light-headedness	__ Excessive Sleep
__ Weight Gain or Loss	__ Numbness or Tingling	__ Loss of Memory
__ Pain	__ Vomiting	__ Eating Problems
__ Headaches	__ Rapid Heart Beat	Other _____

Feelings		**Thoughts**	
__ Helpless	__ Anxious	__ Confused	__ Racing
__ Depressed	__ Out of Control	__ Unintelligent	__ Obsessive
__ Shameful	__ Afraid	__ Worthless	__ Distracted
__ Angry	__ Numb	__ Unmotivated	__ Disorganized
__ Guilty	__ Relaxed	__ Unattractive	__ Paranoid
__ Hopeless	__ Happy	__ Unlovable	__ Suicidal
__ Lonely	__ Excited	__ Confident	__ Sensitive
__ Sad	__ Hopeful	__ Worthwhile	__ Homicidal
__ Stressed	__ Inferiority Feeling		
__ Unhappy	__ Mood shifts	Other _____	
Other _____			

If you need more space, please use the back of this form.

Symptoms/Behaviors/Concerns for the last year

__ Eating Less	__ Acting Out Sexually	__ Socializing
__ Procrastinating	__ Acting Aggressively	__ Marital Relationships
__ Attempting Suicide	__ Disorganization	__ Parent/Child Conflicts
__ Poor Concentration	__ Impulsivity	__ Lack of Ambition/Goals
__ Crying	__ Recklessness	__ Poor Peer Relationships
__ Withdrawing Socially	__ Irritability	__ Nightmares
__ Missing Classes or Work	__ Passivity	__ Worries About Body Image
__ Binge Drinking	__ Drug Use	__ Spiritual Problems
__ Injuring self	__ Alcohol Use	__ Dating Concerns
__ Compulsivity	__ Being Good to Yourself	__ Finances
__ Career issues	__ Sexual Problems	Other _____

Have you ever been emotionally abused? ___ Physically abused? ___ Sexually abused? ___

Your Religious/Spiritual Orientation: _____ Level of Commitment: _____

Your family's religious background when you were growing up: _____

_____

Describe your current religious/spiritual life including any changes: _____

Describe your strengths:

Anything else you would like me to know at this time?

If you need more space, please use the back of this form.