INITIAL PSYCHOTHERAPY INTAKE

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential information. Please fill out this form and bring it your first session.

Part One:

Name:_____ Date of birth:_____ Age: _____
Last First M.I. MM/DD/YYYY

Name of parent or guardian (if under 18 years old): _____
Last *First* *M.I.*

Address: _____
Street Address City State Zip

Gender: _____ Ethnicity:_____ Marital Status: _____

Highest Level of Education: _____ Referred by: (if any) _____

Home Phone: ( ) May we leave you a message? Yes No
Cell Phone: ( ) May we leave you a message? Yes No

E-Mail: _____ May we email you? Yes No
**Please note: E-Mail correspondence is not considered to be a confidential medium of communication.*

Part Two:

History of Presenting Problem- please describe history of symptoms, onset, previous treatment:
_____
_____
_____
_____

Are you currently experiencing overwhelming sadness, grief or depression? No Yes
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or phobias? No Yes
If yes, for approximately how long? _____

Past Psychiatric History- please describe prior treatment, symptoms, past diagnoses, & hospitalizations:
_____
_____
_____
_____
_____
_____

Have you experienced past suicide attempts? Please state how many times and the year in which it occurred:
_____
_____
_____

If you have experienced a history of abuse, please circle: Verbal Physical Sexual Emotional
(*In session with your therapist, you will have an opportunity to discuss the history of abuse you have experienced*)

Family Medical & Psychiatric History- please circle and list family member(s):

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
Personality Disorder(s)	yes/no
Bipolar Disorder	yes/no
Suicide Attempts	yes/no

Medical Conditions and History-
How would you rate your current physical health? Poor / Unsatisfactory / Satisfactory / Good / Very Good
How would you rate your current sleeping habits? Poor / Unsatisfactory / Satisfactory / Good / Very Good
Eating pattern/food issues: _____

Please describe current and past conditions, treatment, allergies, etc.:
_____
_____
_____
_____

Current medications- please describe dosage and frequency:
_____
_____
_____
_____

Substance use past and present- please include alcohol, illicit, prescribed and OTC abuse, withdrawal symptoms, blackouts, longest sobriety, do you drink alcohol more than 1x/week?, how often do you engage in recreational drug use?:
_____
_____
_____

Psychosocial history- please describe past or current school/work issues, family history, relationships, financial, etc.:
_____
_____
_____
_____

Cultural Variables- please describe any cultural variables that may impact the therapeutic process:
_____
_____
_____

Developmental History- please describe development milestones and/or delays:
_____
_____
_____

Educational/Occupational History- please describe level of education, current/past employment:

Legal History- please describe arrest history, sentencing, DUI occurrences, incarceration, etc.:

Are you currently receiving or participating in any community resources? Please explain:

Do you consider yourself to spiritual or religious? Please explain:

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

What do you consider to be some of your strengths?

What do you consider to be some of your limitations?

What you like to accomplish out of your time in therapy?