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Thank you for filling out this form. All information will be kept in strict confidence.

Name ____ Date ________________________

Address ____

Home # __________________ Work # _________________ Cell # ____________________

E-Mail Address ____

I grant permission to leave messages for me regarding scheduling of appointments and/or other matters related to my treatment:

_______ At my home _______ At my office _______ On my cell phone ______Via email

Date of Birth _________________ Age ______________

Occupation _____________________________ Employer ____________________________

How long have you been at your current job? ____________ Last grade completed ________

Ethnicity __________________ Religion _________________

Check one: □ Married/Partnered □ Single □ Separated □ Divorced □ Widowed

Living with Partner/Spouse: □ Yes □ No Number of Years _____

Emergency Contact and Phone:

____

Referred by: (Name & Phone Number): ____

Reason(s) for Seeking Psychotherapy:

Major reason(s) for seeking help at this time:

____

____

How long have you had these problems or symptoms: ___________________________________

Prior Psychotherapy History: Outpatient Psychotherapy, Residential Treatment, Inpatient Hospitalization, etc. (please include names and dates of treatments):

____

____

____

Check all that apply:

	Current	**Past**		**Current**	**Past**
Headaches			Restlessness		
Dizziness			Mood swings		
Stomach problems			Excess energy		
Pain			Euphoric mood		
Drug/alcohol cravings			Excessive spending		
Eating problems			Racing thoughts		
Binge eating			Anger/explosiveness		
Restrictive eating			Panic attacks		
Weight loss			Anxiety		
Weight gain			Excessive worry		
Loss of appetite			Phobias		
Social isolation			Nightmares		
Sleep problems			Physical abuse		
Depressed Mood			Sexual abuse		
Frequent crying			Sexual problems		
Low energy			Relationship Problems		
Feeling worthless			Family conflict		
Suicidal thoughts			Work/school problems		

Psychiatric medications (present and past) ____

____

____

Prescribed by ____

Would you agree to sign a consent for release of information to allow me to converse with the prescribing physician/psychiatrist? □ Yes □ No

Medical Care:

Do you have any serious or chronic medical conditions (past and present): □ Yes □ No

If yes, please list ____

____

Current medications (include non-prescription) _______________________________________

Do you exercise? □ Yes □ No If yes, amount, frequency and type of exercise ___________

____

____

Alcohol and Other Drug Use:

Do you use alcohol? □ Yes □ No If yes, amount and frequency ______________________

Do you use other drugs? □ Yes □ No If yes, amount, frequency and type ______________

Age you started? __________ Date and amount of last use? ______________________________

Do you feel that you have a problem with alcohol and/or other drugs? □ Yes □ No

Has your drinking/drug use caused problems with family or in relationships? □ Yes □ No

Has your drinking/drug use caused problems at work? □ Yes □ No

Have you ever been arrested for a DUI or other drug-related offense? □ Yes □ No

Do you smoke cigarettes? □ Yes □ No

Family/Other Relationship Information:

Have any relatives had psychiatric symptoms or alcohol/drug problems? □ Yes □ No

Relatives	Symptoms/Problems	Treatment

Have you or any family members had legal problems? ◻ Yes ◻ No

If yes, who and why? ____

____

Family data (please add rows below or on the back of page, if needed):

	Name	**City**	**Age**	**Occupation**	**How do you get along?**
Father					
Mother					
Siblings					
Step-Father					
Step-Mother					
Step-Siblings					
Partner/Spouse					
Children					
Step-Children					

Thank you for taking the time to complete this Intake Form. Please attach additional pages if you have additional comments or questions. We will discuss this information in more detail when we meet.