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INTAKE FORM
(confidential)

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Please indicate your preferred phone number for contact.

Cell Phone: _____ May I leave a message? Yes No
Text? Yes No
Home Phone: _____ May I leave a message? Yes No

Work Phone: _____ May I leave a message? Yes No

Email: _____ May I email you? Yes No

Occupation: _____Employer: _____

Level of Education: _____

Educational/Career Aspirations: _____

Insurance Carrier: _____ Phone: _____

Address: _____

Policy Number: _____ Group Number:_____

Primary Insured's Name: _____Insured's DOB: _____

Insured's Employer: _____

Insured's Phone Number: _____

Insured's Address (if different from yours):_____

Emergency contact: _____ Phone: _____

Who referred you? _____

Physician: _____Town_____ Phone:_____

Describe family relationships: _____

_____

Family History (illnesses, losses, mental health issues, alcohol/drug):

_____

_____

Childhood History (parenting, abuse/neglect, school issues, peer problems):

_____

_____

Relationship status (single, partnered, married, etc.): _____

Length of relationship: _____ Quality of relationship: _____

_____

Divorce/Separation Dates (if applicable): _____

Number of pregnancies: _____ Number of children: _____

Names/Ages of children:_____

Describe parent/child relationships: _____

_____

Present health: _____

Medical problems: _____

Hours of uninterrupted sleep/night: _____Eating/Appetite Issues? _____

Past/Present medications including over the counter/herbs (if applicable):

_____

Prescribed by whom: _____

Address: _____ Phone: _____

Recent Stressors (moves, job changes, losses, etc.): _____

_____

Substance use/frequency (cigarettes, alcohol, drugs, etc.): _____

_____

Prior history of counseling/therapy? _____ Dates: _____

With whom: _____ Phone:_____

Why ended? _____

Psychiatric hospitalizations: _____

Purpose for seeking therapy now:_____

_____

Strengths:_____

Challenges: _____

Job Situation: _____

Social Life: _____

Goals: _____

How do you cope with stress? _____

_____

Please check any of the following that apply:

_____Depression	_____Suicidal Thoughts/Attempts	_____Anxiety
_____Fatigue/Low energy	_____Increased/Decreased appetite	_____Weight Gain/Loss
_____Difficulties concentrating	_____Withdrawn/Isolative behavior	_____Insomnia
_____ Excessive sleeping	_____ Grief/loss	_____Poor self esteem
_____ Work issues	_____Panic attacks	_____Cultural issues
_____Self-injurious behavior	_____Relationship issues	_____Irritability
_____Sexual problems	_____Financial problems	_____ Compulsions
_____Alcohol abuse	_____Impulsive/reckless behavior	_____Drug abuse
_____Gambling problems	_____Sexual abuse/assault	_____Mood swings
_____Aggressive behavior	_____Legal problems/arrests	_____Anger
_____Excessive spending	_____Nightmares	_____Trauma
_____Medical problems	_____Identity issues	_____Physical abuse
_____Emotional abuse/neglect	_____Family conflicts	_____ Eating disorder
_____Overly responsible	_____Headaches	_____Guilt

Additional information or questions: _____

_____

_____

_____

_____

_____

_____