Intake Form

Please complete as much of this form as is comfortable before your first psychotherapy or psychological testing session. (This information will be reviewed with you and is only meant to facilitate the intake process.)

1. Patient Contact Information

Patient Name_____ Preferred Name _____
Last First MI

2. How do you describe your race/ethnicity? _____ **3. What is your gender?** _____

3. Current marital status (Check one):
☐ Single, never married ☐ Married, living together ☐ Separated ☐ Widowed ☐ Cohabiting with partner
☐ Divorced ☐ Married, not living together

On a scale from 1-10 how would you rate your current relationship? _____

4. Highest degree obtained: (Check only one)
☐ High school graduate ☐ G.E.D. ☐ 4 year college degree ☐ M.B.A./M.A./M.S./M.P.H. ☐ M.D.
☐ Junior college degree or technical school diploma ☐ J.D./LL.B. ☐ Ph.D ☐ Other_____

5. What best describes your current employment status?
☐ Unemployed, not looking for employment ☐ Unemployed, looking for employment ☐ Full-time employed
☐ Part-time employed ☐ Retired ☐ Self-employed

5a. What is your occupation? _____

6. Please briefly state the primary reason for your visit today:

_____

_____

7. Please rate the intensity of the pain related to your visit today?: _____
0 = No pain, 10 = Worst ever

8. Are you currently receiving mental health care? ☐ YES ☐ NO

(If yes) Name: _____ Contact Number: _____

9. Have you ever seen a psychiatrist/psychotherapist before? ☐ YES ☐ NO

Name: _____ Contact Number: _____

10. **Previous mental history:** Have you ever been treated for any of the following (check all that apply):

I experience problems with:	I have received treatment for this condition:
____ Depression	____ Depression
____ Anxiety	____ Anxiety
____ Panic Attacks	____ Panic Attacks
____ Anorexia/ Bulimia	____ Anorexia/ Bulimia
____ ADHD	____ ADHD
____ OCD	____ OCD
____ PTSD	____ PTSD
____ Binge-eating	____ Binge-eating
____ Bipolar (Manic/Depressive) Disorder	____ Bipolar (Manic/Depressive) Disorder
____ Schizophrenia	____ Schizophrenia

____ Personality Disorders	____ Personality Disorders
____ Alcohol Abuse/Use	____ Alcohol Problems (including AA)
____ Substance Use	____ Substance Use
____ Suicidal or self-injurious behavior	____ Suicidal or self-injurious behavior
____ Relationship difficulties	____ Relationship difficulties
____ Problems coping with stress	____ Problems coping with stress
____ Phobias	____ Phobias

____ Other _____

17. How would you rate your current sleep habits?_1_____5_____10
minimal sleep problems severe sleep problems

18. How would you rate your current eating habits?_1_____5_____10
minimal eating problems severe eating problems

19. Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO
If yes, please provide details below:

20. Have you ever attempted to kill or harm yourself? ☐ YES ☐ NO ☐ More than 1 times

21. Please list all current medications below:

Name of Medication (complete or bring a list to the first session) _____

_____

_____

_____

22. Have you been prescribed psychiatric medication in the past? ☐ YES ☐ NO
If so please list:

23. Family History: Has anyone in your family ever been treated for any of the following? If yes, please indicate on the line provided which family member and, if applicable, whether on mother's side or father's side.

____ Depression	_____
____ Anxiety	_____
____ Panic Attack	_____
____ Post-traumatic Stress	_____
____ Bipolar/Manic Depression	_____
____ Schizophrenia	_____
____ Personality Disorders	_____
____ Alcohol Problems	_____
____ Substance Use	_____
____ ADHD	_____

____ Suicide Attempts _____

____ Psychiatric Hospital Stay _____

24. Medical History: Do you have, or have you ever had any of the following? Please check all that apply.

____ High Blood Pressure
____ Lung Disease
____ Diabetes
____ Heart Disease
____ Thyroid Disease
____ Anemia
____ Asthma
____ Skin Disease
____ Seizures
____ Gastrointestinal Problems (ulcers, pancreatitis, irritable bowel, colitis)
____ Arthritis or Rheumatoid Problems
____ Liver Damage or Hepatitis
____ Other Endocrine/Hormone Problems
____ Neurological Problems (stroke, brain tumor, nerve damage)
____ Gynecological / hysterectomy
____ Urinary Tract or Kidney Problems
____ Migraine or Cluster Headaches
____ Ear/Nose/Throat Problems
____ Viral Illness (herpes, Epstein-Barr, chronic hepatitis)
____ Cancer
____ Genital Problems
____ Eating Disorder
____ Eye Problems
____ Chronic pain
____ Fibromyalgia
____ HIV Positive or AIDS
____ Head Injury
____ High Cholesterol
____ Sleep apnea

Allergies: _____

25. Do you drink alcohol? ☐ YES ☐ NO

26. When was your last alcoholic drink? _____

27. How many drinks do you have on average each week? _____

28. Do you use tobacco? ☐ YES ☐ NO

29. Do you have any concerns for substance use or abuse currently? *Specify:*
_____

30. Do any of the following apply to you?

____ Problems with family or friends *Specify:* _____

____ Emotional problems *Specify*: _____

____ Occupational problems *Specify*: _____

_____

____ Housing problems *Specify*: _____

____ Economic problems *Specify*: _____

____ Problems with access to health care services *Specify*: _____

____ Problems related to interaction with the legal system/crime *Specify*: _____

____ Other psychosocial and environment problems *Specify*: _____

31. What outcome are you seeking by attending therapy at this time?

32. Is there anything else you would like your treatment provider to know about you or your reason for treatment?