I N T A K E F O R M

Please complete the following form and bring it to your first session.
(This information is protected as confidential information)

Name: _____Date: _____

Address: _____
(Street & Number) (City, State) (Zip Code)

Phone: Home _____ Work _____ Cell _____

Cell Phone Carrier (If you wish to receive text appointment reminders): _____

E-mail (Optional, for scheduling purposes only): _____

Date of Birth: _____ /_____ /_____ Age: _____ SSN:_____

Marital Status (please circle): Single Couple Married Separated Divorced Widowed

Children? Names and ages: _____

With whom do you live? _____

Employer: _____ Position: _____

Work Address: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name:_____ Relationship:_____

Address: _____ Phone:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Please list any specific health problems you are currently experiencing: _____

_____

2. Are you currently taking any prescription medications? Please list names and dosages:

_____

3. Please list any specific sleep problems you are currently experiencing:

_____

4. What types of exercise do you participate in? _____Times/week____

5. Please list any difficulties you experience with your appetite or eating patterns:

_____

6. Are you currently experiencing overwhelming sadness, grief or depression?

□ No □ Yes: for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No □ Yes: when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain?

□ No □ Yes: please describe _____

9. Do you drink alcohol more than once a week? □ No □ Yes: do you have any

concerns regarding your alcohol use? _____

10. How often do you engage in recreational drug use? □ Daily □Weekly □ Monthly
□ Infrequently □ Never

11. Are you currently in a romantic relationship? □ No □ Yes: for how long? _____

On a scale of 1-10 (10 best), how would you rate your relationship? _____

12. Please list any significant life changes or stressful events have you experienced recently:

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	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	
Suicide Attempts	yes no	