I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

NAME: _____

(Last) (First) (Middle Initial)

NAME OF PARENT OR GUARDIAN (if client under 18 years):

_____

(Last) (First) (Middle Initial)

Client Birth Date : _____ **Age**: _____ **Gender**: ○ **Male** ○ **Female**

Marital Status: ○ Never Married ○ Domestic Partnership ○ Married ○ Separated ○ Divorced ○ Widowed

Please list any children/age (adult clients) : _____
_____
_____

Address _____

(Street and Number)

_____

(City) **(State)** **(Zip)**

Cell/Other Phone: _____**May we leave a message**? □Yes □No

Insurance Carrier: _____

Insurance ID number:_____

Group Number: _____

Primary Insured Name and Date of Birth: _____

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

Referred by:_____ _____

PRESENTING SYMPTOMS: Please describe as best you can what is the issue/concern for which you or your child are seeking therapy (eg behaviors/mood, when the symptoms first started, how long have they persisted, how are they affecting social and occupational/academic functioning)

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What would you like to accomplish out of your time in therapy? (Child/Adult)

_____
_____
_____
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- ○ No
- ○ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

- ○ Yes**, Prescribing Doctor** _____
- ○ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication at any time?

○ Yes, **Prescribing Doctor and telephone number:**

_____

○ No

Please list drugs and dates taken:

_____

_____

LEGAL:

1. **Are there any legal issues that we need to be aware of (e.g DCF, custody, police**)

□ Yes _____

□ No

SCHOOL(child client):

1. **What is the name of your current school?**

_____

2. **What grade are you in?**

_____

3. **Have you repeated a grade? (if so which grade)**

_____

4. **Do you receive any extra help at school? (If so what)**

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. **How would you rate your current physical health? (please circle)**

Poor	Unsatisfactory	Satisfactory	Good	Very good
○	○	○	○	○

Please list any specific health problems you are currently experiencing:

_____

Name of PCP (Primary Care Doctor):_____

Phone number of PCP : _____

2. **How would you rate your current sleeping habits? (please circle)**

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. **How many times per week do you generally exercise?** _____

What types of exercise do you participate in: _____

4. **Please list any difficulties you experience with your appetite or eating patterns.**

_____

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

- No
- Yes:

If yes, for approximately how long and symptoms?

_____

_____

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

- No
- Yes

If yes, when did you begin experiencing this and symptoms?_____

_____

7. **Are you currently experiencing any chronic pain?**

- No
- Yes

If yes, please describe: _____-

8. **Do you drink alcohol more than once a week?** ○ No ○ Yes

9. **How often do you engage recreational drug use**? **Yes_____ No_____**
Frequency? ○ Daily ○ Weekly ○ Monthl ○ Infrequently ○ Never

Drugs of Choice:_____

10. **Are you currently in a romantic relationship?** ○ No ○ Yes

If yes, for how long? _____

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

11. What 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
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 ○	

ADDITIONAL INFORMATION:

1. **Are you currently employed**? ○ No ○ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work/ Is there anything stressful about your current work?

_____

_____

2. **Do you consider yourself to be spiritual or religious?** ○ No ○ Yes

If yes, describe your faith or belief:

_____

3. **What do you consider to be some of your strengths? (Child/Adult)**

_____

_____

_____

_____

4. **What do you consider to be some of your weaknesses? (Child/Adult)**

_____

_____

_____

_____