



Intake Form

Basic Information:

Date:

Patient Name:

Date of Birth:

Gender: Male Female

Ethnicity:

Home Address:

Home Phone Number:

May we leave a message? Yes No

Work Phone Number:

May we leave a message? Yes No

Mobile Phone Number:

May we leave a message? Yes No

Referral Source

Who referred you to our office, or how did you learn about our practice?

Emergency Contact Information

In case of an emergency, who should we contact?

Name:

Relationship:

Address:

Phone Number:

History Information

Who is providing the history information?

The patient

The patient's guardian

Other

Please describe the current complaint or problem as specifically as you can, in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Check all words/phrases that describe what you are experiencing and explain if possible.

Substance abuse/dependence

Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.)

Depression/Sad/Down feelings

- High/Low energy level
- Angry/Irritable
- Loss of interest in activities
- Difficulty enjoying things
- Crying spells
- Decreased motivation
- Withdrawing from people/Isolation
- Mood Swings
- Black and white thinking/All or nothing thinking
- Negative thinking
- Change in weight or appetite
- Change in sleeping pattern
- Suicidal thoughts or plans/Thoughts of hurting yourself
- Self-harm/Cutting/Burning yourself
- Homicidal thoughts or plans/Thoughts of hurting others
- Poor concentration/Difficulty focusing
- Feelings of hopelessness/Worthlessness
- Feelings of shame or guilt
- Feelings of inadequacy/Low self-esteem
- Anxious/Nervous/Tense feelings
- Panic attacks
- Racing or scrambled thoughts
- Bad or unwanted thoughts
- Flashbacks/Nightmares
- Muscle tensions, aches, etc.
- Hearing voices/Seeing things not there
- Thoughts of running away
- Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
- Feelings of frustration
- Feelings of being cheated
- Perfectionism
- Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
- Distorted body image (believe you are heavier or less attractive than others say you are)
- Concerns about dieting
- Feelings of loss of control over eating
- Binge eating/Purging
- Rules about eating/Compensating for eating
- Excessive exercise
- Indecisiveness about career
- Job problems
- Other:

Previous Treatment

Have you received or participated in previous counseling and/or therapy?

Yes No

Additional Information:

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?
Is there any type of treatment you would like to continue?
Have you had hospital stays for psychological concerns?

Yes No

Additional Information:

Are you currently experiencing thoughts of harming either yourself or someone else?

Yes No

Have you in the past experienced thoughts of harming either yourself or someone else?

Yes No

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you?

Yes No

If yes, explain:

Did you walk, talk, and read on time?

Yes No

Explain:

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times?

Are you satisfied at where you are in your life?

If not, where would you like to be?

Medical History

List any current or important past medications:

Medication & Dose:

Response to Medication:

History of serious childhood illnesses:

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime:

Have you experienced any head injuries?

Yes No

Important Details:

If yes, did you lose consciousness?

Yes No

Have you experienced convulsions or seizures?

Yes No If yes, did you also have a fever? Yes No

Explain any allergies you have:

How would you rate your current physical health?

Excellent

Very Good

Good

Fair

Poor

Very Poor

What was the date of your last physical or routine health “check up”?

Do you have a primary care physician?

Yes No

If yes, complete the following:

Name:

Address:

Phone Number:

Do you see a psychiatrist?

Yes No

If yes, please complete following:

Name:

Address:

Phone Number:

Family History

Birth Location:

Raised by: Mother Father Step-Mother Step-Father Other:

Relationship with parent figures:

(good, fair, poor, close, distant, etc.)

Mother:

Father:

Step-parent:

Other:

List your siblings and describe your relationship with them?

Name

Age

Gender

Nature of Relationship

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

Any family history of substance abuse, mental illness, suicide, or violence?

Any Additional Family Information:

Social History

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Describe any cultural concerns:

Educational History

When attending school where you:

- In Regular Classes
- Home Study
- Special Classes
- Advanced Classes
- Ever suspended
- Placed in alternative school

What is the highest educational level you have completed?

Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

Occupational History

What is your current employment status?

- Employed Full-Time
- Employed Part-time
- Unemployed
- Self-employed
- Student
- Other

Are you satisfied with your employment?

If not, why?

Marital History

Which best describes your marital status?

- Married, Month/Year: _____
- Never Married
- Widowed, Month/Year: _____
- Separated, Month/Year: _____
- Divorced, Month/Year: _____

If you are married, please briefly describe nature of your marital relationship:

If you are married, which best describes your marital satisfaction?

- Poor Fair Good Great

Please list any previous marriages/significant relationships including current:

Name:

Date:

Nature of Relationship:

Do you have children?

- Yes No

If yes, complete the following:

First Name

Age

Gender

Nature of Relationship

Are there presently any child custody issues involving you or your family?

Yes No

Does your family currently have Child Protective Services Involvement?

Yes No

If yes please complete the following:

Case Worker's Name:

Phone:

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, opiates, or other)

Yes

No

If you answered yes, please complete the following substance abuse history chart.

Please list following details next to substances used:

Age of First Use:

Current Frequency of Use:

(Daily, Weekly, Monthly)

Amount Used:

How did you use it? (smoked, injected, etc.)

Alcohol

Marijuana

Cocaine or Crack

Heroin

Amphetamines

Club Drugs (Ecstasy, Inhalants, etc.)

Pain Medication (Oxycontin, Vicodin, etc.)

Benzodiazepines

Hallucinogens

Other

Complete the following if you have ever received treatment for a substance abuse issue.

Name of Treatment Program:

Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization,

Recovery House, Counseling, Methadone, Suboxone):

Date of Treatment (Month, Year):

Outcome (Length of Sobriety):

What was your longest period of sobriety:

Legal History

Do you currently have any pending criminal charges?

Yes No

Are you on probation?

Yes No

Name of Probation Officer and County

Have you ever been arrested/convicted of a crime?

Yes No: If yes, complete chart.

List any Arrests/Convictions

Date of Arrests/Convictions

Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.)

Additional Information

Summarize your goals for counseling/therapy:

What expectations do you have for counseling/therapy?

Name 5 things you would like to change about yourself.

What are your strengths?

What are your weaknesses?

Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible?

Is there anything not asked on this form that you would like your therapist to know? Please list below:

Signature of client or guardian

Date