INTAKE FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Spouse Name)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip)

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May I contact you via e-mail? Y/N

Guardian E-mail (if under 18 yrs):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May I contact you via e-mail? Y/N

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religious Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes No

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes No

Spouse Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes No

Guardians Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes No

Referred By (If any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I send a thank you note? Yes No

Referral Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_

Place of Work (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you happy with your job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list others in your family or living with you:

Name Date of Birth Relationship to you

1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INDIVIDUAL CONCERNS**

|  |  |
| --- | --- |
| Name | Date |

Check any of the following terms that apply to you (S = Self) or a family member (F = Family).

|  |  |  |
| --- | --- | --- |
| **S F**  Depressed mood  Lost interest or pleasure Lack of energy/fatigue  Weight gain or loss  Unable to concentrate  Excessive sleeping  Difficulty sleeping  Decreased need for sleep  Pressure to keep talking  Racing thoughts  Excessive risk taking behavior  Panic Attacks  Excessive fear of situation or object  Reoccurring thoughts or impulses  Repetitive behaviors to reduce  stress  Witness/experience event  threatening life or serious injury  Excessive anxiety or worry  Hear/see things others do not  Memory problems/ Memory loss  Suicidal Thoughts | **S F**  Significant ongoing physical pain  Stomach problems  Headaches  Bowel problems  Balance problems  Seizure problems  Learning/Academic problems  Stuttering problems  Frequent problems with attention  Frequent “on the go” behavior  Impulsive behaviors  Temper  Aggressive behavior toward others  Destructive behaviors  Frequent lying/deceitfulness  Problems following rules  Sexual problems  Eating Problems  Nightmares  Gambling Problems | **S F**  Alcohol usage  Drug usage  Marital problems  Divorce  Separation  Affair  Problems with ex/spouse  Relationship problems  Parenting problems  Problems with friends  Problems with children  Legal problems  Work/job problems  Financial problems  School problems  Shyness  Anger  Loneliness  Insecurity  Isolation |

If you have noticed any recent changes in the following areas, please circle those changes.

Vision Hearing Coordination Balance Strength Speech Memory

Energy Sleeping Menstrual cycle Elimination Eating Sexual activity Thinking

List any additional medical problems you may experience:

List all medications you are taking:

Medication Dosage Prescribed by Date prescription began

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any counseling or therapy you or a member of your family are receiving or have received:

Therapist Address When Family Member(s)

Have you ever been physically, sexually, emotionally abused? No Yes

If yes, briefly describe:

Have you ever been hospitalized for mental or nervous problems? No Yes

If yes, when and where?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? No Yes

If yes, where, when and how many attempts?

Are you suicidal now? No Yes

Do you drink alcohol? No Yes

If yes, what is your typical drink and how often do you drink alcohol?

Age first used alcohol\_\_\_\_\_\_ Age of heaviest/most frequent use \_\_\_\_\_\_\_ Use in last three months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been arrested for driving under the influence (DUI)? No Yes If yes, how many times? \_\_\_\_\_\_\_\_\_\_

Do you use drugs? No Yes

If yes, what drugs do you use and how often?

Age first used drug(s) \_\_\_\_\_\_ Age of heaviest/most frequent use \_\_\_\_\_\_\_ Use in last three months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been arrested? No Yes If yes, how many times and for what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently involved or do you expect to be involved in any court-related matters? No Yes

If yes, please describe:

What is it in your marriage, family or individual life that brings you to therapy?

What kinds of stressors are you experiencing right now?

What important things about your marriage or family would it be helpful for your student therapist to know? (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)

Do you have any concerns about violence or abuse in your family? Alcohol or drug usage? Please describe them.