**INTAKE FORM**

*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.*

**Section 1: Personal Information**

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

 (First) (Middle) (Last)

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

 (Number and Street)

 (City) (State) (Zip)

Mobile Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_Messages Okay? \_\_\_No \_\_\_Yes: \_\_\_Voice \_\_\_Text

Home Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_Messages Okay? \_\_\_No \_\_\_Yes

Work Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_Messages Okay? \_\_\_No \_\_\_Yes

Emergency Contact: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Birth Sex: \_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Unknown

Gender Indentity: \_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Transgender Male/Trans Man/FTM

\_\_\_\_ Transgender Female/Trans Woman/MTF \_\_\_\_ Choose not to disclose

\_\_\_\_ Gender Queer, neither exclusively male nor female

\_\_\_\_ Additional gender category or Other, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation: \_\_\_\_\_ Lesbian/Gay/Homosexual \_\_\_\_\_ Straight/Heterosexual

\_\_\_\_\_ Bisexual \_\_\_\_\_ Something else please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Unknown \_\_\_\_\_ Choose not to disclose

Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Languages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_ Married \_\_\_\_ Single \_\_\_\_ Other

Employment: \_\_\_\_employed \_\_\_\_ full-time student \_\_\_\_ part-time student

\_\_\_\_ unemployed/other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: Contacts to coordinate treatment:**

*These contacts will not be called without discussing it first and/or written permission given.*

Name of Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Psychiatrist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Guardian(s) (if under 18 years old):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3: Background Information:**

Please describe the problem or issues you are experiencing that led you to seek out therapy:

Please describe when these problems or issues started, how often they bother you, and any symptoms you experience from the problems or issues:

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

\_\_\_\_ No \_\_\_\_ Yes, previous therapist/practitioner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been prescribed psychiatric medication? \_\_\_\_ No \_\_\_\_Yes

Please list and provide dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been diagnosed with a mental illness? \_\_\_\_ No \_\_\_\_ Yes

Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for a mental illness? \_\_\_\_ No \_\_\_\_ Yes

Please list approximate dates and reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you ever attempted suicide? \_\_\_\_ No \_\_\_\_Yes

Please list approximate dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever engaged in self-injurious behaviors? *(ex: cutting on yourself, hitting yourself)*

\_\_\_\_ No \_\_\_\_ Yes Date of last incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma History? *(deaths, abuse, violence, etc.)*: \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Not that I am aware of

\_\_\_\_ I am not comfortable at this time disclosing this information

If yes, please briefly describe here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Mental Health History:

*In this 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 Disorder yes/no

Schizophrenia yes/no

Bipolar Disorder yes/no

Suicide Attempts yes/no

Do you have any current or past medical conditions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you currently taking any prescription medication? \_\_\_\_ No \_\_\_\_ Yes:

Please list name, dosage, and prescribing physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Do you drink alcohol more than once a week? \_\_\_\_No \_\_\_\_Yes: \_\_\_ drink(s) / day / week

Do you use cannabis? \_\_\_\_No \_\_\_\_Yes: \_\_\_ Daily \_\_\_ Weekly \_\_\_ Monthly

How often do you use other drugs? \_\_\_ Daily \_\_\_ Weekly \_\_\_ Monthly \_\_\_Infrequently

 \_\_\_ Never Date of last use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Living:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_Deceased:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (city where she lives) (date of death)

Father’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Living:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_Deceased:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (city where he lives) (date of death)

Do you have siblings? \_\_\_\_\_No \_\_\_\_\_Yes:

If yes, please list your siblings names and their ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you have any children? \_\_\_\_No \_\_\_\_\_Yes

If yes, please list their name(s) and age(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in a relationship? \_\_\_\_\_No \_\_\_\_\_Yes

If yes, for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you currently have one or two close friends? \_\_\_\_\_No \_\_\_\_Yes

If yes, please list their first names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your developmental history: \_\_\_\_\_Normal \_\_\_\_\_Delayed

If delayed, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of education: \_\_\_\_\_I am currently a student at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_I have some high school credits \_\_\_\_\_I am a high school graduate year of \_\_\_\_\_\_\_

\_\_\_\_\_I have some college credits \_\_\_\_\_I am a college graduate year of \_\_\_\_\_\_\_\_

Degree/Major:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of college:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?

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

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Have you ever been arrested? \_\_\_\_No \_\_\_\_Yes

If yes, please explain when and what the charges were for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you ever gone to jail? \_\_\_\_\_No \_\_\_\_\_Yes

If yes, please explain why:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently involved in any legal proceedings? \_\_\_\_\_No \_\_\_\_\_Yes

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you consider to be some of your strengths?

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

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What do you consider to be some of your limitations?

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

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What would you like to accomplish out of your time in therapy?

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