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Intake Form

This form requests information about you (or your child), which will be helpful in planning your services. Please take a few moments to complete the form carefully. I appreciate your time in completing these documents.

PERSONAL INFORMATION

Name: _____ Today's Date: _____

Age _____ Date of Birth _____Social Security # _____

Address _____
Street City Zip

Home Phone _____ Can I leave a message at this number? _____

Cell Phone _____ Can I leave a message at this number? _____

Emergency Contact _____ Relationship to you _____

Phone number _____

Marital Status: _____Single _____Married _____Living together Years together _____

Spouse's Name: _____ Age: _____ Occupation: _____

Children? _____ Names and ages _____

Level of Education: ____High School /GED ____Some College ____Bachelors ____Post Graduate

Occupation _____ How many hours do you work per week? _____

List any health problems past or present? _____

_____

When were you last examined by a physician? _____

Name of your Primary Care Physician: _____Phone: _____

Physician's Address: _____

May I contact your physician, if necessary? Yes/No _____ Please initial

List any medications you are currently taking _____

_____

Name of prescribing physician _____ Phone: _____

Alcohol use – How often do you drink alcohol and how much? _____

Drug use – How often do you use recreational drugs and which drugs? _____

_____

Have you been in therapy before? _____ First seen: _____ Last seen:_____

Reasons for seeking therapy in the past? _____

_____

_____

Describe your reason(s) for seeking therapy at this time. Please include when the problem started._____

_____

_____

Which symptoms below contributed to your reasons for seeking therapy at this time?

___ rapid heart rate
___ compulsive behaviors
___drug use
___ depressed mood
___ sweating
___ impulsive behaviors
___ odd behavior/thoughts
___ crying
___ trembling or shaking
___ fears/phobias
___ recent weight gain
___ difficulty concentrating
___ shortness of breath
___ anxiety
___ recent weight loss
___ low motivation
___ muscle tension
___ vomiting
___ recent appetite changes
___ aggressive behavior
___ outbursts of temper
___ distrust
___ social withdrawal
___ feelings of worthlessness
___ nightmares
___ sexual problems
___ family emotional problems
___ stomach problems
___ easily distracted
___ dizzy or lightheaded
___ chest pain
___sleeping too much
___ decreased need for sleep
___ fatigue/loss of energy
___ difficulty falling asleep
___ problems at work
___ feeling self-conscious
___ obsessions
___ difficulty staying asleep
___ pain
___ alcohol use
___ relationship problems
___ experienced a traumatic event
___ financial problems
___ can't turn my mind off
___ thoughts of hurting myself

INSURANCE INFORMATION

Insurance provider _____Policy holder _____

Identification number _____ Group number _____

Phone number to verify benefits _____ Copayment _____

FAMILY INFORMATION

Relationship	First Name	Age	City, State currently living in	Occupation or Grade in School	Deceased (Yes or No)
Mother					
Father					
Stepmother					
Stepfather					
Brother					
Brother					
Sister					
Sister					
Step brother or sister					
Other siblings					
Other Siblings					

Referred by _____ How do you know this person? _____