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Intake Form

Name: __________________________ Nickname:____________________

Age: _______ Date of Birth: __/__/___ Biological Sex:_________

Address:

____

____

Gender: ________ Relationship Status: ____________________________

May I contact you by email? _______ Phone? ______ Postal Mail? ________

E-mail Address: ____

Phone: _________________ Can I leave a message? _____

In case of emergency please notify: _______________________________________

Phone: ________________________ Relationship to client: ________________

How did you learn about my services? (Check all that apply):

o Psychologytoday.com

o Yelp.com

o Blue Cross Blue Shield Physician Directory

o Comfyfitness.com

o Facebook

o Friend/Relative

o Passing by the office

o Google/Google Places

o Other:_________________________

Briefly tell me about the issues/concerns that have brought you here:

____

____

____

____

Please check any current or past issues that still affect you:

___ Eating Disorders/Body Image

___ Pregnancy Issues

___ Academic Issues

___ Spiritual Concerns

___ Childhood Abuse (ie. Physical, sexual, emotional)

___ Depression

___ Pornography

___ Phobias (type: ________________)

___ Alcohol/Other Drug Use

___ Relationship Concerns

- ___ Family
- ___ Friend
- ___ Parent
- ___ Roommate
- ___ Significant Other
- ___ Coworker

___ Stress/Anxiety

___ Family Issues (ie. Divorce, alcoholism, domestic violence)

___ Sexual Problems

___ Sexual Assault/Rape

- ___ Recently (When: _______)
- ___ In the past

___ Death of someone close

- ___ Recently (When: ________)
- ___ In the past

____Other: ____________________________

Medical History

Current medical problems:

____

____

____

Current medications (all, including herbal)

____

____

Have you been on any medications in the past for mental health issues?

____

Are you currently working with a psychiatrist? ______

If yes, what is your doctor's name? ________________________ Phone Number: _______________

What is the psychiatrist treating you for?____

Have you previously seen a therapist? ________ Who/Where? ______________________________

How long ago? ______________ For what? ____

Have you ever been hospitalized for physical or mental health issues? _____(Briefly describe):

____

____

Have you had any previous suicide attempts?: ______ Briefly Describe: ______________________

____

If you are currently experiencing any of the following symptoms, please rate them using the number key below:

Never **0** Seldom **1** Often **2** Always **3**

___ Difficulty concentrating

___Memory loss or blackout

___ Crying

___ Difficulty sleeping

___ Missing work/class

___ Stealing

___ Feeling helpless

___ Feeling afraid

___ Anger

___ Feeling uptight/tense

___ Eating binges

___ Worrying

___ Drinking heavily

___ Feeling hopeless

___ Other drug use

___ Feelings of guilt

___ Lying to others

___ Withdrawing socially

___ Feeling out of control

___ Self-injuring

___ Loneliness

___Nervousness around others

___ Sexual preoccupation/obsessions

___ Feelings of self-doubt

___ Suicidal thoughts

___ Physical symptoms (i.e. headaches, digestive)

___ Other: ____________

What do you hope to get out of our work together?

____

____

____

____

____