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Intake Information:

Name DOB Date_____

Address City State Zip_____

Telephone numbers_____

Is it okay to leave message?____

Emergency Contact: _____Telephone:_____

Email_____

Combined household income (used to determine your fee per

session)__***Private pay clients only***._____

Insurance Provider and membership numberr

_____

Did someone refer you?_____

MD/ND Contact info :

_____

_____

Reason(s) for seeking therapy:

_____

_____

_____

_____

_____

_____

Why now?

_____

_____

_____

Date problem/concern began:

_____

_____

Brief history of the problem/concern:

_____

_____

_____

_____

_____

Previous therapy for the problem/complaint? With whom?_____

Yes___ No___

If yes, dates and brief description. Was it helpful?

_____

_____

_____

_____

Current symptoms: (circle all that apply)

Sleep disturbances changes in appetite difficulty w/ concentration loneliness moodiness sad angry irritable anxious hopelessness panic attacks cycling repetitive thoughts bad dreams changes in weight increase in unhealthy behaviors suicidal thoughts/wishing you were dead decrease in ability to have fun or enjoy activities that used to be pleasurable physical pain/discomfort changes in relationships w/ family, friends or co-workers

Level of satisfaction with employment (circle one)

1 2 3 4 5 6 7 8 9 10

Level of satisfaction with primary relationship; partner, spouse (circle one)

1 2 3 4 5 6 7 8 9 10

Level of satisfaction with family relationships; children, siblings, parents (circle one)

1 2 3 4 5 6 7 8 9 10

Any other complaints, problems or issues that are not listed above:

_____

_____

_____

_____

Recent important events/changes in life or lives of significant others i.e. divorce, loss of a loved one, move, new family member, employment

_____

_____

_____

_____

Current medical condition/concerns:

_____

_____

_____

_____

Medications both prescribed and over the counter and supplements:

Medication/Condition: Amount: Prescriber:

_____

_____

_____

Hospitalizations: Year: Cause: Outcome:

_____

_____

_____

_____

Relationship History (relationships/years/marriage/divorces/domestic partnerships):

_____

_____

_____

_____

Substance Use:

Alcohol How long?_____ How much? _____

Frequency? Last used?_____

Street Drugs How long?___ How much?_____

Frequency? Last used?_____

Changes in use? Problems or complaints via you or someone else?

_____

_____

_____

_____

Treatment? When, where and level of success:

_____

_____

Current Source of relaxation, rejuvenation, relaxation, joy, exercise:

_____

_____

Do you have a support network?

_____

_____

Who lives in your home?

_____

_____

Family history of mental health issues? Drug or alcohol abuse? Neglect?

_____

_____

_____

_____

What are your strengths?

_____

_____

_____

_____

What are your weaknesses?

_____

_____

_____

_____

How would others describe you?

_____

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

_____

_____

_____

_____

Is there anything not mentioned on this form that would be helpful for me to know?

_____

_____

_____

_____

What should we work on first? Next?

_____

_____

_____

_____

_____

_____

How will you know when you are done with therapy?

_____

_____

_____

_____