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INTAKE FORM

Please complete this form and email it before to our first meeting. If you have any questions or concerns, please feel free to discuss them with me. If you prefer not to answer a question, feel free to leave it blank. All information will be kept confidential within the limits of the law.

General Information

Name: _____Today's Date: _____

Date of birth: _____ Age: _____ Ethnicity/race: _____

Referred by:
_____

Address:
_____

Phone (h): _____ (c): _____ (w): _____

Best way to contact:
_____

Education level: _____ Occupation: _____

Employer: _____ How long at job? _____

Emergency Contact: _____ Phone: _____

Psychological History

Have you participated in therapy previously? Yes _____ No _____
If yes, please indicate when and for how long, describe the focus and outcome of treatment:

_____

_____

Are you currently taking any medication(s) for a psychological condition? Yes _____ No _____

If yes, please list the medication, dosage, prescribing doctor, and start date(s):

Have you previously taken any medication(s) for a psychological condition? Yes _____ No _____
If yes, please list the medication, dosage, prescribing doctor, and start/end date(s):

Have you ever experienced any suicidal thoughts in the past? Yes _____ No _____
If yes, please describe the thoughts and when they occurred:

Are you currently experiencing any suicidal thoughts? Yes _____ No _____
If yes, how often do these thoughts occur and when was the last time?

Have you ever attempted suicide? Yes _____ No _____
If yes, please describe the circumstances that led to the attempt and when it occurred:

Have you ever been hospitalized for an emotional or psychological condition? Yes _____ No _____
If yes, please describe the reason(s) for the hospitalization, when it occurred, and for how long:

Have you experienced any significant emotional losses recently or in the past? Yes _____ No _____
If yes, please describe:

Have you experienced any significant stressors recently? Yes _____ No _____

If yes, please describe:

Have you ever been subjected to verbal, physical, emotional, or sexual abuse? Yes _____ No _____

If yes, please describe:

Have you ever threatened to harm another person or property? Yes _____ No _____

If yes, please describe:

Do you own or have access to any guns or weapons? Yes _____ No _____

If yes, please indicate the type of weapon(s) and where it or they are stored:

Medical History

Are you allergic to any medications or other substances? Yes _____ No _____

If yes, please describe:

Have you ever been diagnosed with a serious illness? Yes _____ No _____

If yes, please describe:

Have you ever had a serious accident, surgery, head injury, or seizure(s)? Yes _____ No _____
If yes, please describe:

Do you currently have any medical condition(s)? Yes _____ No _____
If yes, please describe:

Are you currently taking any prescription medication(s) for a medical condition? Yes _____ No _____
If yes, please list the medication, dosage, and prescribing doctor.

Do you currently use any nonprescription medication(s) or supplements? Yes _____ No _____
If yes, please describe:

Date of your most recent physical examination:
_____

Name of your primary care physician:
_____

Please describe your overall health today:
_____

Do you smoke? Yes _____ No _____
If yes, what and how often?

Do you drink alcohol? Yes _____ No _____
If yes, please indicate your preferred type of drink and preferred number of drinks:

Are you currently using any non-prescribed or recreational drugs? Yes _____ No _____
If yes, please describe your use:

Have you ever used any non-prescribed or recreational drugs in the past? Yes _____ No _____
If yes, please describe your use:

Have you ever tried to cut down on your drinking or drug use? Yes _____ No _____
If yes, when and why?

Have you ever participated in drug or alcohol treatment? Yes _____ No _____
If yes, please describe the type of treatment, when it occurred, and the outcome:

Family History

Has anyone in your family ever had a psychiatric diagnosis? Yes _____ No _____

If yes, please indicate name(s) of the individual(s), diagnosis, and relation to you:

Does anyone in your family have a history of alcohol or drug problems? Yes _____ No _____

If yes, please indicate who and describe the nature of their substance use or abuse:

Is there any other important or relevant information that you would like to share?

Thank you for completing this form!

Signature of Client: _____

Date: _____