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INTAKE FORM

Please provide the following information and answer the questions below. Please note that the information you provide here is protected as confidential information. Some of this information may feel private and/or stir up uncomfortable emotions, so please feel free to discuss any of the feelings that come up from this questionnaire. Thank you.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Engaged □ Married

□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □Yes □No

Cell/Other Phone: ( ) May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication and will not be used for clinical communication. It may be used for billing and scheduling, at times.

Emergency Contact Person: _____ Phone #_____
*Please note, this person will only be contacted in the case of a true emergency and your confidentiality will be protected under California law.

Referred By: _____Phone #_____

Primary Care Physician: _____Phone #_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list:
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing.

_____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe. _____

8. How often do you drink alcohol?_____

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never □ Other_____

What types of drugs?
_____

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

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

FAMILY MENTAL HEALTH HISTORY:

In the 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 Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

CURRENT RISK ASSESTMENT:

Any risk factors present?: yes/no

If yes, specify current risk factors:

Any potential for violence?: yes/no

Hostile/ Abusive behavior: yes/no

Major Depression: yes/no

Suicidal Ideation/Intent/Plan: yes/no

PAST RISK FACTORS:

Suicide Attempts:	yes/no
Violent Behavior:	yes/no
Inpatient Hospitalization:	yes/no
Hostile/Abusive behavior:	yes/no
Major Depression:	yes/no
Suicidal Ideation/Intent/Plan:	yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____
_____
_____

4. What do you consider to be some of your weaknesses?

_____
_____
_____

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

_____
_____
_____
_____
_____