

Name _____ Date _____

INTAKE FORM

All of the information that you provide in this intake is confidential and cannot be released without your consent.

What is the reason that you're attending therapy at this time?

HEALTH & WELLNESS

Do you have any physical health problem(s) Y ___N___ If yes, list condition(s):

List all medications you are currently taking: (prescribed, over the counter, and others). Use back of form if necessary

Medication	Dosage	Taken for	When started
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How many times per week do you exercise? _____

Approximately how long each time? _____

Menopause (Check the symptoms that apply to you)

Hot flashes___ Insomnia___ Fatigue___ Memory Loss___ Mood Swings___

Irregular Menses___ Painful Intercourse___ Increased Libido___

Decreased Libido___ Disturbed Sleep Pattern

Current physician or medical agency:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Date _____

FAMILY MENTAL HEALTH HISTORY:

List members in your family that may have or is experiencing difficulties with the following?

Difficulty	Family Member
Depression	_____
Bipolar Disorder	_____
Anxiety Disorders	_____
Panic Attacks	_____
Schizophrenia	_____
Alcohol/Substance Abuse	_____
Eating Disorders	_____
Learning Disabilities	_____
Traumas	_____
Suicide	_____

Educational Background

Highest educational level/training _____

CURRENT FAMILY INCOME (annual):

Below \$25,000 ___ \$25,000 - \$50,000 ___ \$50,001 - \$75,000 ___
\$75,001 - \$100,000 ___ \$100,000 - \$150,000 ___ Above \$150,000 ___

Lifestyle

Has anyone complained about your drinking/drug use? Y ___ N ___
Have you ever felt guilty over your drinking/drug use? Y ___ N ___
Do you typically have a drink to get going in the morning? Y ___ N ___
Has your alcohol/drug use caused problems
at work, home, or personal life? Y ___ N ___
Have you ever blacked out from alcohol/drug use? Y ___ N ___
Have you been *charged* with a DUI Y ___ N ___
Do you smoke cigarettes? Y ___ N ___
How often do you have 4 or more drinks in a 24-hour period? _____

What do you consider to be your strengths? _____

What are your goals for therapy? _____