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

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_____________________

BEHAVIORAL HEALTH
Check any of the following that you currently experience:

Sleep disturbance___ Appetite disturbance___ Fatigue___ Poor concentration___ Memory problems___ Depression___ Suicidal thoughts___ Suicidal plan___ Homicidal thoughts___ Excessive anxiety___
Panic attacks ___ Frequent anger/Irritation ___ Extreme depressed mood ___
Mood swings ___ Rapid speech ___ Phobias ___ Sleep disturbances ___
Hallucinations ___ Memory lapses ___ Eating disorder ___
Repetitive thoughts (e.g., Obsessions)___ Repetitive behaviors (e.g., Frequent checking, Hand washing)

List any significant life changes or stressors in the past:

____

____

RELIGIOUS/SPIRITUAL ORIENTATION

What is your religious or spiritual orientation?____________________________

MARITAL RELATIONSHIP HISTORY

Are you currently in a relationship? Y ___ N ___ How long? ____________

	Past		Current	
Domestic spousal abuse/violence	Y ___	N ___	Y ___	N ___
Physical abuse	Y ___	N ___	Y ___	N ___
Emotional abuse	Y ___	N ___	Y ___	N ___
Sexual abuse or assault	Y ___	N ___	Y ___	N ___

How satisfying is your relationship? (circle one)

1	2	3	4	5
not satisfying				very satifying

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___ $50,000 - $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? ____________________________________

____