Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. Please print or write clearly and bring it with you to the first session.

Client Name: _____ Age: _____ Date: _____

Circle: M / F DOB: _____ Ethnicity: _____ Marital Status: _____

Address: _____ Zip _____

Telephone: Home: _____ Cell: _____ W/Off: _____

Occupation: _____ Employer: _____

Education: _____ Referral Source: _____

Person to contact in case of emergency: _____Phone: _____

Presenting Problem (be as specific as you can: when did it start, how does it affect you…):

_____

_____

_____

_____

Estimate the severity of above problem (circle): Mild Moderate Severe Very severe

Please check if you are experiencing problems with any of the following:

☐ Depression	☐ Nervousness	☐ Alcohol Use	☐ Marriage
☐ Suicidal Thoughts	☐ Fears	☐ Drug Use	☐ Friends
☐ Self-Worth	☐ Shyness	☐ Health Concerns	☐ Children
☐ Self-Control	☐ Anger	☐ Stomach problems	☐ Changes in Appetite
☐ Loneliness	☐ Temper	☐ Legal Problems	☐ Nightmares
☐ Low/No Motivation	☐ Relaxing	☐ Conflicts at Work	☐ Sleeping too Much
☐ Concentration	☐ Problems Coping	☐ Finances	☐ Difficulty Sleeping
☐ Unhappiness	☐ Stress	☐ Making Decisions	☐ Feeling Tired

People currently living with you (include names, ages and relationship):

1._____

2._____

3._____

4._____

5. _____

Primary Physician: _____ **Date of Last Exam:** _____

Current Medications: _____

_____

Please list any major health concerns (past or present):_____

_____

Past/Present Drug/Alcohol Use/Abuse: (AA, NA, treatments)**:** _____

_____

Suicide Attempts or **Hospitalizations** (include dates, ages, reasons, circumstances, how, etc)**:**

_____

_____

Violent Behaviors (describe situation, actions and outcome):_____

_____

Previous Marriages (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile)**:**

_____

_____

Children (names/ages & brief statement on your relationship with the person):

1._____
2._____
3._____
4._____
5._____

Parents/Step-parents (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father: _____

_____

Mother: _____

_____

Step-parents_____

_____

Siblings (name/age, if deceased: age and cause of death & brief statement about the relationship):

1._____
2._____
3._____
4._____

Describe your childhood in general: Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

If Parents Divorced: Your age at the time: _____ Describe how it affected you at the time:

_____

_____

Family History of Alcoholism, Mental Illness, or Violence (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

Family Medical History (Describe any <u>illness</u> that runs in the family: cancer, epilepsy, etc)**:**

_____

_____

Friendships, Community, & Spirituality (quality, frequency, activities, etc.):_____

_____

Past/Present Psychotherapy (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1. _____

_____

_____

2. _____

_____

_____

Use other side of the page for more information about psychotherapists

Current/Pending Civil or Criminal Litigations, Lawsuits or Divorce/Custody Disputes please explain):

_____

_____

What gives you the most joy or pleasure in your life?

_____

_____

What are your main worries and fears?

_____

_____

What are your most important hopes or dreams?

_____

_____

Please use this space and/or the other side of the page for any other information you would like me to know about you and your situation.