Intake Form

Please answer the questions below. Please note: the information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:_____

Name of parent or guardian if under 18 years:_____

Marital Status:

___Never Married ___Domestic Partnership ___Married

___Separated ____Divorced ___Widowed

Please list any children/age:_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services) ?

____No

____Yes, previous practitioner_____

Are you currently taking any prescription medication?

____No

____Yes Please list:_____

Have you ever been prescribed psychiatric medication?

____No

____Yes Please list and provide dates:_____

_____

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:_____

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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:

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3. What types of exercise do you participate in and how many times per week:_____
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 For approximately how long?_____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

   ____No

   ____Yes When did you begin experiencing this?_____

7. Are you currently experiencing any chronic pain?

____No

____Yes Please describe:_____

8. Do you drink alcohol more than once a week?

____No

____Yes How much do you drink:_____

9. How often do you engage in recreational drug use:

____Daily ____Weekly ____Monthly ____Infrequently ____Never

10. Are you currently in a relationship?

_____No

____Yes For how long?_____

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

11. What significant life changes or stressful events have you experienced recently:

_____

_____

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.

Alcohol/Substance Abuse no yes_____

Anxiety no yes_____

Depression no yes_____

Domestic Violence no yes_____

Eating Disorders no yes_____

Obesity no yes_____

Obsessive Compulsive Disorder no yes_____

Schizophrenia no yes_____

Suicide Attempts no yes_____

Additional Information

1. Are you currently employed? _____no

____yes, What is your current employment situation?_____

_____

_____

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 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 in your therapy or coaching?

_____

_____