INTAKE INFORMATION and HISTORY

Client: ____ Date: ________________
Parent/Guardian Name, if client is under age 18: ____
Client DOB: ________________ Email Address: ____
Home Phone: __________________ Work Phone: __________________Cell: __________________
Street Address: _________________________________ City: __________________ Zip: _________

MEDICAL/INSURANCE INFORMATION

Insured Name: __________________________ DOB: ________________ SSN: ________________
Your Insurance Plan: ___________________________ Member #: ____________________________
Physician's Name: _____________________________ Phone #: _____________________________
Physician's Address: ____

HISTORY

Married ____ Partnered ____ Single ____ Separated ____ Divorced ____ Widowed ____
List any children/age: ____
Have you previously received any type of therapy or psychiatric services? No ________ Yes _________
Are you currently taking any prescription medication? No ________ Yes _________
List meds if yes: ____
Have you ever been prescribed psychiatric medication? No ________ Yes _________
List and provide dates: ____

FAMILY MENTAL HEALTH HISTORY

Identify if there is a family history of any of the following: If yes, indicate the family member's relationship to you (example: father, mother, grandfather, grandmother, aunt, uncle, cousin, etc.)

	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	Yes/No	______________________________
Schizophrenia	Yes/No	______________________________
Bipolar Disorder	Yes/No	______________________________
Suicide Attempts	Yes/No	______________________________

PRESENTING PROBLEM

Why are you seeking help? ____
____
Are you in crisis? ____

How would you rate your current physical health?
Poor ____ Unsatisfactory ____ Satisfactory ____ Good ____ Very Good ____ Excellent _____
List any health problems you are currently experiencing: ____
____
How would you rate your current sleeping habits?
Poor ____ Unsatisfactory ____ Satisfactory ____ Good ____ Very Good ____ Excellent _____
List any sleep problems you are currently experiencing: ____
How many times a week do you exercise? ____
What kind of exercise do you do?____
List any difficulties you experience with your appetite or eating patterns:___________________________
____
Are you currently experiencing overwhelming sadness, grief or depression? _______________________
Are you currently experiencing anxiety, panic attacks or have any phobias? _______________________
Are you currently experiencing any chronic pain? ____
Do you drink alcohol more than once a week? Yes ________ No _________
How often do you engage in recreational drug use? Daily ____ Weekly ____ Monthly ____ Never ____
Are you currently in a romantic relationship? ______ If yes, for how long? _______________________

ADDITIONAL INFORMATION
Are you currently employed? Yes ________ No _________
If yes, what is your current employment situation?____
Do you enjoy your work?____
Do you consider yourself spiritual or religious? Yes ________ No _________
If yes, describe your religious or spiritual belief: ____
Describe some of your strengths: ____
Describe some of your weaknesses: ____
Share what you hope to get out of therapy:____
____

LEGAL
For Minors: If parents are divorces:
Who has legal custody?____
Who has physical custody?____
Are there pending custody issues?____
Are there any child abuse issues?____
Are there any legal issues?____
For Adults:
Have you ever been involved in domestic violence?____
Have you ever been arrested?____
Have you ever been sued?____
Are you suing anyone?____

EMERGENCY CONTACT ____
Home Phone: ___________________ Work Phone: ___________________ Cell: __________________