INTAKE FORM

Please print out and complete this form and bring it with you to your first session.
Also, bring photo government issued identification to your first session.
Please provide the following information
Information that you provide is confidential

Name: _____
(Last) (First) (Middle)

Birth Date: _____/_____/_____/ **Age:** _____ **Gender:** _____
(Month) (Date) (Year)

Marital Status: ☐ Never Married ☐ Domestic Partner ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Children and age: _____

Address:_____
(Street and Number)
_____
(City) (State) (Zip Code)

Home Telephone: (____) _____ May I leave Message: ☐ Yes ☐ No
Cell Phone: (_____)_____ May I leave Message: ☐ Yes ☐ No
Email: _____ May I send email: ☐ Yes ☐ No
What is your preferred method to receive communication?_____

Referred by: _____

Have you previously received any type of mental health services? (psychological, psychiatric, counseling et cetera). ☐ Yes ☐ No

List previous therapists or doctors and treatment

_____
_____

Are you currently prescribed any psychiatric medication: ☐ Yes ☐ No
Medication:_____dose_____Prescriber:_____
Medication:_____dose_____Prescriber:_____

Are you taking any medications of any kind? List:

_____

Are you taking any vitamins, minerals, herbs etc? List:

_____

General Health and Mental Health

How would you rate your current physical health:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

□ list any physical symptoms and diagnoses:

□ _____

_____

How would you rate your current cognitive health:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

□ list any mental or cognitive symptoms and diagnoses:

□ _____

_____

How would you rate your current emotional health:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

□ list any emotional symptoms and diagnoses:

□ _____

_____

How do you rate your current sleep:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

□ Any difficulty falling asleep ?_____ , difficulty staying asleep? _____

□ Any Nightmares? _____

□ Any Night Terrors? _____

How do you rate your current appetite:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

□ Any recent weight gain?_____. Any recent weight loss? _____

Any GI Problems? ☐ Yes ☐ No

How do you rate your current libido:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

How do you rate your current attention/concentration:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

How do you rate your ability to be mindful?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

How do you rate your ability to remain present in the moment?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Are you physically restless ?_____ , fidgety ?_____ , uneasy? _____, without purposeful movement? _____

How do you rate you energy level?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Are you currently experiencing overwhelming grief, sadness, depression?

☐ Yes ☐ No

If yes, for how long? _____

Are you currently experiencing overwhelming anxiety, panic attacks, phobias?

☐ Yes ☐ No

If yes, for how long? _____

Are you currently experiencing overwhelming worry, racing thoughts, continuous thoughts?

☐ Yes ☐ No

If yes, for how long? _____

Are you currently experiencing any physical pain?

☐ Yes ☐ No

If yes, for how long? _____
Type and location of pain:_____
Intensity of Pain on 1 to 10 scale: _____

How often do you exercise? _____
How often do you meditate?_____
How often do you spend time in the sun? _____
How often do you spend time at the ocean? _____
How often do you spend time under the moon?_____
How many liters of water do you drink per day?_____
How often are you engaged in active learning/ Brain exercise? _____

How often do you use:
Alcohol?_____
Cigarettes?_____
Recreational drugs of any type? □ Yes □ No
Do you use any form of drug to escape emotional pain or use to numb emotional pain? or use to calm racing thoughts? □ Yes □ No

Are you currently in a romantic relationship? □ Yes □ No
If yes, for how long? _____ **How would you rate your romantic relationship?** _____ **on a scale of 1 to 10:**
1=poor 10: excellent

If not in a romantic relationship, for how long alone? _____

What significant life situations, stressors, life changes have you experienced recently?

_____
_____
_____
_____
_____

Family Mental /Emotional Health

In the section below identify any family member who had a history of the following and their relationship to you (i.e. father, mother, uncle, etc.)

Anxiety:	□ Yes	□ No	Relationship:_____
Depression:	□ Yes	□ No	Relationship:_____
Alcohol Abuse:	□ Yes	□ No	Relationship:_____
Substance Use:	□ Yes	□ No	Relationship:_____
Suicide attempts:	□ Yes	□ No	Relationship:_____
Thought Disorder:	□ Yes	□ No	Relationship:_____
Dementia:	□ Yes	□ No	Relationship:_____
Violence:	□ Yes	□ No	Relationship:_____

List any other family history:

_____
_____
_____
_____

Additional Information

Highest academic education with diploma:_____

Are you currently employed: □ Yes □ No

Profession: _____

Is your employment/work rewarding? □ Yes □ No

Are you Spiritual practitioner: □ Yes □ No

Are you Religious practitioner: □ Yes □ No

If yes, describe your faith, belief, and any practice:

_____

_____

What are your Strengths:

_____

_____

_____

What would you like to accomplish with therapy/ What are your goals?

_____

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