Intake Form

Name: ______________________________ Date: ______________

Presenting Problems and Concerns

Describe the problem that brought you here today:

____

____

When did it start and how does it affect you:

____

____

Estimate the severity of the above problem:

Mild Moderate Severe Very Severe

Please check all of the behaviors and symptoms that you consider problematic:

Distractibility	Change in appetite	Paranoia
Hyperactivity	Lack of motivation	Racing thoughts
Impulsivity	Isolation	Too much energy
Boredom	Anxiety/Worry	Mood Swings
Poor memory	Panic attacks	Social discomfort
Phobias	Obsessive thoughts	Sleep problems
Compulsive behaviors	Sadness/Depression	Loss of pleasure
Hopelessness	Helplessness	Thoughts of death
Self-harm behaviors	Loneliness	Low self-esteem
Guilt/Shame	Fatigue	Nightmares
Eating problems	Gambling problems	Aggression/Fights
Computer addiction	Problems with pornography	Sexual Problems
Parenting problems	Frequent arguments	Irritability/Anger
Homicidal thoughts	Flashbacks	Alcohol/Drug use
Relationship problems	Work/School problems	Hearing voices
Visual hallucinations	Other ______________	

Are your problems affecting any of the following?

Work/School	Self-esteem	Relationships
Hygiene	Housing	Legal matters
Finances	Recreational activities	Sexual activity
Health	Everyday tasks/functioning	

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Have you ever had thoughts, made statements, or attempted to hurt yourself? YES NO If yes, please describe:

___

Have you ever had thoughts, made statements, or attempted to hurt someone else? YES NO If yes, please describe:

___

Family and Developmental History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/Partner			
Children			

Family Mental Health Problems	Who?
Depression	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Eating Disorders/Disordered Eating	
Hyperactivity	
Sexually Abused	
Bipolar	
Anger/Abusive	
Alcohol Abuse	
Substance Abuse	

Schizophrenia	
Completed Suicide	
Psychiatric Hospitalizations	

Parents legally married or living together — Mother remarried: # of times __
Parents temporarily separated — Father remarried: # of times __

Please check if you have experienced any of the following types of trauma or loss:

- Emotional abuse
- Sexual abuse
- Physical abuse
- Parent substance abuse
- Financial problems
- Neglect
- Violence in the home
- Crime victim
- Parent illness
- Lived in a foster home
- Multiple family homes
- Homelessness
- Loss of a loved one

Past/Present Psychotherapy (specify: month years (beginning to end), estimated number of sessions, initial reason for therapy and how helpful it was and why it ended:

1)____
____
____
____
____

2)____
____
____
____
____

3)____
____
____
____
____

Medical Information

Name of Primary Care Physician: ____
Date of last physical exam: ____
Have you experienced any of the following medical conditions during your lifetime?

- Allergies
- Chronic pain
- Dizziness/fainting
- Asthma
- Surgery
- Meningitis
- Headaches
- Serious accident
- Seizures
- Stomach aches
- Head injury
- Vision problems

High fevers	Diabetes	Hearing problems	Miscarriage
STDs	Abortion	Sleep disorders	Other ______________

Please list any CURRENT health concerns: ____

Current prescription medications: None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter mediations (including vitamins, herbal remedies, etc.):
____
____

Allergies and/or adverse reactions to medication: None
If yes, please list: ____

Substance Use History

Substance Type	Current Use (last 6 mos.)				Past Use			
	Y	N	Freq	Amount	Y	N	Freq	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
LSD								
PCP								
Steroids								
Benzodiazepines								

Have you had withdrawal symptoms when trying to stop using any substances?
YES NO If yes, please describe:
____
____

Have you ever had problems with work, relationships, health, the law, etc., due to your substance use? __YES __NO If yes, please describe:
____
____

Interpersonal/Social/Cultural Information

Please describe your social support network (check all that apply):
__Family __Neighbors __Friends __Co-workers __Community Group
__Religious/Spiritual Center

To which cultural or ethnic group do you belong? ____________________________

How important are spiritual matters to you? __Not at all __Little
__Somewhat __Very much

Describe any special areas of interest or hobbies:
____
____
____

Additional Information

Employment
Employer: ______________________________ Position: ______________________
Stress level of this position: __Low __Medium __High

Education
Are you currently attending school? __Yes __No
__High School Graduate? __GED Year________
College Degree ________________________ Year ______ Major ______________

Military Service
Have you been/are you currently in the military? __Yes __No
Branch ______________ Date of Discharge ____________
Type of Discharge____________ Rank _______________

Were you in combat? __Yes __No

Legal
Have you ever been convicted of a misdemeanor or felony? __Yes __No If yes, please explain____

Are you currently involved in any divorce or child custody proceedings? __Yes __No

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

What are your most important hopes or dreams?

Additional Comments: