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Intake Information:

Name___________________________________ DOB_______________________ Date______

Address___________________________ City__________________ State__________ Zip_________

Telephone numbers

H____________________ W____________________ C____________ okay to leave message?____

Emergency Contact: ___________________________Telephone:______________________

Email____

Combined household income (used to determine your fee per session)____

MD/ND Contact info:
____
____
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Reason(s) for seeking therapy:
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Why now?
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Date problem/concern began:

____
____
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Brief history of the problem/concern: ______________________________________
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____
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Previous therapy for the problem/complaint? *Yes* *No*______________________

If yes, dates and brief description. Was it helpful?
____
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Current symptoms: (circle all that apply)

Sleep disturbances changes in appetite difficulty w/ concentration loneliness moodiness sad angry irritable anxious hopelessness panic attacks cycling repetitive thoughts bad dreams changes in weight increase in unhealthy behaviors suicidal thoughts/wishing you were dead decrease in ability to have fun or enjoy activities that used to be pleasurable physical pain/discomfort changes in relationships w/ family, friends or co-workers

Level of satisfaction with employment (circle one)

1 2 3 4 5 6 7 8 9 10

Level of satisfaction with primary relationship; partner, spouse (circle one)

1 2 3 4 5 6 7 8 9 10

Level of satisfaction with family relationships; children, siblings, parents (circle one)

1 2 3 4 5 6 7 8 9 10

Any other complaints, problems or issues that are not listed above:

Recent important events/changes in life or lives of significant others i.e. divorce, loss of a loved one, move, new family member, employment

Current medical condition/concerns:

Medications both prescribed and over the counter and supplements:

Medication/Condition: Amount: Prescriber:

Hospitalizations:

Year: Cause: Outcome:

Relationship History (relationships/years/marriage/divorces/domestic partnerships):

Substance Use:

Alcohol	How long?	How much?
Frequency?	Last used?	
Street Drugs	How long?	How much?
Frequency?	Last used?	

Changes in use? Problems or complaints via you or someone else?

Treatment? When, where and level of success:

Current Source of relaxation, rejuvenation, relaxation, exercise:

Do you have a support network?

Who lives in your home?

Family history of mental health issues? Drug or alcohol abuse? Neglect?

What are your strengths?

What are your weaknesses?

How would others describe you?

What are your goals for therapy?

Is there anything not mentioned on this form that would be helpful for me to know?

What should we work on first? Next?

How will you know when you are done with therapy?

____
____
____
____
____