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Psychotherapy Intake Form

Identifying Information:

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Ethnicity/Race:_____ Gender: _____

Address_____

Telephone #:_____ (mobile/home/work) Email: _____

May I leave a message on your voicemail? Yes No

May I email you regarding scheduling or appointment time information? Yes No

Please note that email is NOT considered a means of confidential information. Please do not email me confidential or private information

Emergency Contact Name:_____ Telephone #: _____

Please describe the primary reason(s) for which you are seeking therapy at this time:
_____
_____
_____
_____

How did you find out about my office / who referred you?
_____

Please check any of the concerns that you are having or have had recently:

Depression	Feeling hopeless	Trouble Concentrating
Memory Problems	Change in sleeping habits	Change in eating habits
Worrying/anxiety	Racing thoughts	Lack of energy
Panic attacks	Feeling nervous	Sudden feelings of panic
Muscle tension	Compulsive behaviors	Perfectionism
Self-esteem problems	Easily irritated	Feeling stressed
Memories of past trauma	Hallucinations	Suicidal/self-harm thoughts
Physical pain	Thoughts of harming others	Anger

Please add useful details regarding concerns checked above:
_____
_____
_____
_____

Previous Mental Health Treatment:

Name of Provider	Dates of Treatment	Reason for Treatment

Are you currently experiencing any of the following emotional stressors?

Death/loss of loved one Financial difficulty Family/relationship problems
Health problems Job difficulties Other: _____

Family history: Do, or did, any of your biological relatives (parents, grandparents, aunts/uncles, children) have any mental health difficulties that you are aware of? Yes No

If yes, please describe:

_____
_____
_____
_____

Social History:

Current living situation:

alone with partner/spouse with children with parents with roommates

Indicate your current relationship status:

Single Married/Partnership Divorced Separated Widowed

Have you ever been abused in any of the following ways?

None Physical Verbal Emotional Sexual

Educational History:

Your highest level of formal education:_____

Degree(s) earned: (check all that apply)

_____GED
_____HS diploma
_____Associates degree
_____Bachelors degree Major_____
_____Masters degree In what?_____
_____Doctoral degree In what?_____

How were your grades in school?

above average (As and Bs) average (Bs and Cs) below average (Ds and Fs)

Sleep habits:

What is your usual bedtime?_____ What time do you usually arise?_____
Do you awaken feeling well rested? Yes No
Do you take frequent daytime naps? Yes No

Occupational History:

Are you currently employed: Yes No

If yes, describe your current job:_____

Length of employment?_____

If no, which of the following circumstances apply:

Disabled, not able to work Seeking compensation for injury Seeking work

Retired, specify for how many years _____ Other: specify _____

The job that you worked the longest_____

Medical History:

Current Primary Physician Name: _____

Address: _____

Telephone: _____

Have you ever had any of the following conditions?

				Still a problem?	
	Yes	No	Year began	Yes	No
Balance or falling problems	____	____	_____	____	____
Cancer	____	____	_____	____	____
Diabetes	____	____	_____	____	____
Dizziness	____	____	_____	____	____
Fainting spells	____	____	_____	____	____
Head Injury*	____	____	_____	____	____
Heart disease/heart attack	____	____	_____	____	____
High blood pressure	____	____	_____	____	____
Infection of the brain	____	____	_____	____	____
Kidney disease	____	____	_____	____	____
Lack of oxygen to the brain	____	____	_____	____	____
Lung disease	____	____	_____	____	____
Memory Loss	____	____	_____	____	____
Migraine of cluster headaches	____	____	_____	____	____
Multiple sclerosis	____	____	_____	____	____
Numbness	____	____	_____	____	____
Paralysis	____	____	_____	____	____
Parkinson's disease	____	____	_____	____	____
Seizures, convulsions, epilepsy	____	____	_____	____	____
Sleep apnea	____	____	_____	____	____
Stroke	____	____	_____	____	____
Thyroid disease	____	____	_____	____	____
Transient ischemic attacks (TIA)	____	____	_____	____	____
Tremor	____	____	_____	____	____
Other, specify_____	____	____	_____	____	____

*Have you experienced any blows to the head where you felt dazed, confused, disoriented, or were "seeing stars"? Yes No

- If yes, how many times?_____
- If yes, did you lose consciousness during any of these events? Yes No

Your current medications:

Medicine, info of dosage For what condition?

1._____
2._____
3._____
4._____
5._____

Smoking History:

Do you smoke? Yes No If yes, how many packs per day? _____
If no, did you ever smoke? Yes No Year quit? _____

Alcohol/Drug History:

Do you drink alcohol?
Occasionally Regularly Never

How many drinks do you consume in a typical week? _____

Do you use "street" drugs?
Occasionally Regularly Never

Have you had any of the following problems because of alcohol or other drugs?
Social, marital, or work problems aggressive behavior (fighting) legal problems

Leisure Activities:

Please list your most frequent leisure activities:

Activity How Often?

1._____
2._____
3._____

Thank you for taking the time to complete this form. Please ask any questions you have.