INTAKE & ASSESSMENT FORM

Please provide the following information and answer the questions below. Please note: The information you provide here is protected as confidential information.

Name: _____

Address:_____

Home phone:_____Cell phone:_____

Work phone:_____ Email:_____

May we leave a message? Yes / No Referred by (if any):_____

Name of parent/guardian (if under 18 years):

_____

Birth Date:___/___/_____Age:_____ Gender: Male / Female Ethnicity:_____

MARITAL STATUS (please circle)

Never Married Separated Married Engaged Widowed Divorced Domestic Partnership

Single

Please list any children/ages, if any, including step-children. If your children are adopted, please note current age and when adopted. If any are deceased, please list date of death:

_____

_____

_____

- ☐ I am in a serious relationship and we live together.
- ☐ I am in a serious relationship and we do not live together.

Please list previous marriages and/or serious relationships:

_____

_____

Please answer the following if you are with your partner now:

What is your partner's name:_____

What is your partner's occupation:_____ How long together:_____

WORK HISTORY

Occupation:_____ How long?_____

Employer:_____ Telephone:_____

Employer Address:_____

If unemployed: Student, Full / Part Time Homemaker Retired Other

EMERGENCY CONTACT

Name:_____ Relationship to You:_____

Address:_____City_____State_____Zip___

Daytime Phone:_____ Evening:_____

PHYSICAL HISTORY (please circle)

General Health: Very Good Good Satisfactory Unsatisfactory Poor

Are you now under a Physician's care? YES / NO

If so, what is the name /address /phone of your Physician:_____

_____

Reason for being under Physician's care:_____

Are you currently taking any prescription medications, over the counter medications, vitamins, herbs, supplements, etc? If so, please list the name, dosage, frequency and reason: _____

_____

_____

_____

Have you ever been hospitalized for a **physical** illnesses, major illnesses or surgeries?

_____

Any recurrent or chronic conditions? YES NO

If so, please list:_____

MENTAL HEALTH HISTORY

Have you ever received any type of **mental health services** (psychotherapy, psychiatric services, etc.)? YES / N0

If so, please list when, reason and where you received services:

_____

_____

Have you ever been or currently on any prescribed psychiatric medication? If so, please list:

_____

_____

Have you had any past **psychiatric** hospitalizations? YES NO

If so, please state where, when, and reason for hospitalization.

_____

_____

Have you ever had any accidents where you may have had an injury to your head (as a child or adult)?_____

_____

_____

Have you ever, or do you currently use any recreational substances (illegal drugs)? If so, please list what type & how often:_____

_____

_____

Do you smoke cigarettes? YES NO If so, please describe how long and how much per day:

_____

Do you drink alcohol? YES NO If so, please describe how often and how much per week:

_____

Do you consider any of your substance use to be a problem? YES NO

If yes, please describe:_____

_____

_____

How would you rate your current sleeping habits? (Circle all that apply)

Poor Unsatisfactory Satisfactory Good Very Good

Sleeping too little sleeping too much poor sleep disturbing dreams other

Night terrors sleepwalking sleep apnea (trouble breathing)

Estimate how many hours per night, on an average, you sleep:_____

Do you feel rested / refreshed when you wake up in the morning?_____

How would you describe your eating habits and appetite (circle all that apply)?

Poor unsatisfactory satisfactory good very good other

Eating more eating less binging purging restricting significant wt. change

How many times per week do you exercise?_____

What type of exercise do you do?_____

How long do you exercise each time?_____

Did you have a form of religious upbringing?_____

Do you consider yourself to be spiritual or religious? YES NO

Do you have a present belief, church or affiliation?_____

_____

Is this belief an important part of your life?_____ If so, please describe.

_____

_____

_____

Do you have any problems or concerns about sexual functioning? YES NO (If so, please circle all that apply):

Lack of desire performance problems sexual impulsiveness other

Difficulties maintaining arousal painful intercourse sexually transmitted diseases

Have you ever, or do you currently have thoughts about killing yourself or hurting someone else?

_____

_____

Have you ever made any attempts?_____

_____

Do you have any history of traumas such as childhood or adult sexual abuse (molestation, rape, or incest), physical (beatings, assaults) or emotional abuse (verbal & mental)?_____

_____

_____

_____

_____

ADDITIONAL INFORMATION

Are you currently experiencing overwhelming sadness, grief, or depression? YES NO

If yes, for approximately how long?_____

Have you recently experienced any major loss, such as death of family/friend, breakup of a relationship, moves, etc.?_____

_____

_____

_____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

_____

_____

Are you currently experiencing any chronic pain?_____

_____

What significant life changes or stressful events have you experienced recently?_____

_____

_____

_____

_____

Are you currently experiencing strong emotions? YES NO If yes, describe:

_____

_____

Do you make decisions based on your emotions? YES NO If yes, how well does that work for you?

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

How much of your immediate family a source of emotional support for you (circle one)?

NONE LITTLE SOMEWHAT SUBSTANTIAL VERY STRONG

Besides family members who do you count on right now for friendship or emotional support (please name and note relationship to you)?

_____

_____

Goals for Therapy: What would you like to accomplish out of your time in therapy and what would you like to experience that is different from what you are experiencing now?

_____

_____

_____

_____

_____

_____

FAMILY BACKGROUND QUESTIONNAIRE & FAMILY SYSTEMS INFORMATION

Please check and past or impending issues that applies to you, your parent/s and/or siblings.

	SELF	MOTHER	FATHER	SIBLING(S) (specify which sib.)
ALCOHOL ABUSE				
DOMESTIC VIOLENCE				
DRUG ABUSE				
EMOTIONAL PROBLEMS				
PSYCHIATRIC HOSPITALIZATIONS				
ANXIETY				
DEPRESSION				
SCHIZOPHRENIA				
BIPOLAR				
OBSESSIVE COMPULSIVE DISORDER				
OTHER MENTAL ILLNESSES				

ULCERS OR COLITIS				
ASTHMA				
SERIOUS PHYSICAL ILLNESS				
WEIGHT/EATING PROBLEMS				
ANOREXIA				
OBESITY BULIMIA				
INSOMNIA				
ATTEMPTED / COMPLETED SUICIDE				
EPILEPSY				
PHYSICAL ABUSE				
SEXUAL ABUSE				
DEBILITATING INJURIES/DISABILITIES				
NUMEROUS CHILDHOOD ILLNESSES				
FREQUENT RELOCATIONS				
LEARNING PROBLEMS				
DEATHS				
DIVORCE				
FINANCIAL CRISIS/ UNEMPLOYMENT				
LEGAL PROBLEMS				
OTHER				

If reared by someone **other** than your birth parents, describe situation in detail:_____

_____

_____

_____

Was there any family alcoholism or domestic violence in your home growing up?_____

_____

Were there any sexual addictions or abuse in your home growing up?_____

_____

Are your parents married or divorced?_____ If divorced, how old were you when they divorced?_____

If divorced, are either of them re-married?_____

How many marriages for mother?_____Spouse's name:_____

If mother is living with a partner, how long and partner's name?_____

_____

How many marriages for father?_____ Spouse's name:_____

If father is living with a partner, how long and partner's name?_____

_____

Any step-parents? YES NO if yes, describe when and your relationship with them:_____

_____

_____

_____

Is your mother still living? YES NO Where does she reside?_____

How would you describe your relationship with her?_____

_____

_____

Is your father still living? YES NO Where does he reside?_____

How would you describe your relationship with him?_____

_____

_____

Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M / F Age_____#2 M / F Age_____ #3 M / F Age_____#4 M / F Age_____

#5 M / F Age_____#6 M / F Age_____#7 M / F Age_____#8 M / F Age_____

(CIRCLE ALL THAT APPLY TO YOU)

Sadness	Excessive Behaviors (Spending, Gambling, Sex, Drugs)
Low Energy	Delusions / Hallucinations
Low Self Esteem	Not Thinking Clearly / Confusion
Poor Concentration	Depersonalization / Feeling That You Are Not Real
Hopelessness	Disassociation / Not Feeling Connected
Helplessness	Derealization / Feeling That Things Around You Are Not Real
Worthlessness	Feeling Like A Failure
Guilt	Loses Track Of Time
Fatigue	Unpleasant Thoughts That Won't Go Away
Tearful	Anger / Frustration
Memory Problems	Fidgety Or Restless
Sleep Disturbance (More / Less)	Easily Annoyed / Irritable / Annoys Others
Appetite Disturbance (More / Less)	Defies Rules
Thoughts Of Hurting Yourself	Blaming Others
Thoughts Of Hurting Someone Else	Spiteful / Vindictive
Mood Swings	Uses Obscene Language
Hyper vigilance / Very Sensitive	Argumentative
Isolation / Social Withdrawal	School Problems
Grief / Loss	Learning Disorder
Stress	Relationship Problems
Somatic Concerns (Body Pains)	Family Problems
Anxiety / Panic	Work Problems
Headaches	Legal / Financial Problems
Heart Pounding / Palpitations	Eating Problems
Chest Pain	Cutting
Trembling / Shaking	Excessive Use Of Drugs And / Or Alcohol
Sweating / Flushes / Chills	Excessive Use Of Prescription Medications
Abdominal Distress	Excessive Use of Over The Counter Medications
Hot Or Cold Flashes	Blackouts
Tingling / Numbness	Physical Abuse Issues
Fear Of Dying	Sexual Abuse Issues
Fear Of Losing Control	Spousal Abuse Issues
Fear Of Going Crazy	Feeling Suicidal
Feeling Afraid Or Paranoid	Hearing Voices
Dizziness / Nausea	Hallucinating
Fears / Phobias	
Obsessive Thoughts	Other Problems / Symptoms: (Please List)
Compulsive Behaviors	•
Hyperactive	•
Racing Thoughts	•
Trouble Concentrating	•
Forgetful	
Easily Agitated	

Are you taking any Over-The-Counter / herbal medications? (Type / Frequency / Dosage / Duration / Uses)

_____

Medications currently prescribed & reason: (Type / Frequency / Dosage / Duration / Uses)

_____

_____

_____

Doctor's Name:_____Address:_____

Phone: _____ When were you last seen for this condition?_____