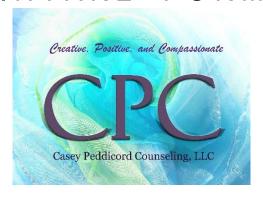
INTAKE FORM



Please note: information you provide here is protected as confidential information. Name: ___ (Last) (First) (Middle Initial) Birth Date: ____/___Age: __ Identify as: □ Male □ Female □ Gender Fluid Relationship Status: □ Never Married □ Married □ Domestic Partnership □ Separated □ Divorced □ Widowed □ Monogamous □ Polyamorous Please list any children/age: Address: ___ (Street and Number) (City) (Zip) (State) Home Phone: May we leave a message? □ Yes □ No Cell/Other Phone: (May we leave a message? □ Yes □ No) May we email you? □ Yes □ No *Please note: Email correspondence is not considered to be a confidential medium of communication. Referred by (if any):

	Have you previous services, etc.)?	ously received any type	of mental health serv	rices (psycho	therapy, psychiatric				
	□ No								
	□ Yes, previous	therapist/practitioner: _							
	Are you currently	y taking any prescriptio	n medication?						
	□ Yes								
	□ No								
	Please list:								
	Have you ever b □ Yes □ No	een prescribed psychia	atric medication?						
	Please list and p	provide dates:							
	GENERAL HEA	LTH AND MENTAL HE	ALTH INFORMATIO	N					
1.	How would you	rate your current physic	cal health? (please c	ircle)					
	Poor	Unsatisfactory	Satisfactory	Good	Very good				
	Please list any s	specific health problems	s you are currently ex	periencing:					
2.	How would you	rate your current sexua	ıl/intimacy health? (p	lease circle)					
	Poor	Unsatisfactory	Satisfactory	Good	Very good				
	Please list any s	specific sexual health is	sues/problems you a	re currently e	experiencing:				
3.	How would you	rate your current sleepi	ing habits? (please c	ircle)					
	Poor	Unsatisfactory	Satisfactory	Good	Very good				
	Please list any s	specific sleep problems	you are currently exp	eriencing:					

4.	How many times per week do you generally exercise?
	What types of exercise to you participate in?
5.	Please list any difficulties you experience with your appetite or eating patterns:
6.	Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes
7.	If yes, for approximately how long?Are you currently experiencing anxiety, panic attacks, or have any phobias? No Yes
	If yes, when did you begin experiencing this? How do symptoms present? (e.g. dizziness, rapid heartbeat, nausea etc.)
8.	Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:
9.	Do you drink alcohol more than once a week? □ No □ Yes
10	. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
11	Are you currently in a romantic relationship? No Yes If yes, for how long?
	On a scale of 1-10, how would you rate your relationship?
12	. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY	′ :					
In the section below, identify if there is a family history of any of the following. If yes, ple indicate the family member's relationship to you in the space provided (father, grandmot uncle, etc.).						
	Please Circle	List Family Memb				
Alcohol/Substance Abuse	yes/no					
Anxiety	yes/no					
Depression	yes/no					
Domestic Violence	yes/no					
Eating Disorders	yes/no					
Obesity	yes/no					
Obsessive Compulsive Behavior	yes/no					
Schizophrenia	yes/no					
Suicide Attempts	yes/no					
ADDITIONAL INFORMATION:						
1. Are you currently employed?	□ No □ Yes					
If yes, what is your current employment situation?						
Do you enjoy your work? Is there any	thing stressful about you	r current work?				

If yes, descr	ribe your faith or belief:
3. What do	you consider to be some of your strengths?
4. What do	you consider to be some of your weaknesses?
5. What wol	uld you like to accomplish out of your time in therapy?
	nings you think I should know?