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Personal Information and Intake Form

Having this important information about you will help me to best serve you.
The information you provide here is held to the same standards of confidentiality as our therapy.

Today’s Date: ______/______/________

Name: ____
(Last) (First) (MI)

Your Birth Date: _____ /_____ /_________ Age: ______ Gender: □ Male □ Female □ Trans/non-binary

Address:

____
(Street and Number)

____
(City) (State) (Zip)

Preferred Phone: ________________________________ May I leave a message? □Yes □No

Alternate Phone: ________________________________ May I leave a message? □Yes □No

E-mail: ____ May I email you? □Yes □No
*Please be aware that email and text may not be as secure as other communications.

Emergency Contact Person: Name _______________________________ Phone: _________________________

Nature of relationship to you _______________________________

What prompts you to seek therapy now? (Issues, challenges, goals)

In the last year, have you experienced any significant life changes or stresses?

Have you had previous psychotherapy? □ No □ Yes

- If yes, why and when?

____

- Are you hopeful about your future? □ Yes □ No

Have you ever been hospitalized in a psychiatric facility? □ Yes □ No If Yes, when? ______________________

Are you <u>currently</u> taking prescribed psychiatric medications? (antidepressants or others) □ Yes □ No

- If Yes, please list names and doses: ____
- If No, have you been previously prescribed psychiatric medication? □ Yes □ No
- If Yes, please list names and approximate dates: ____

Are you having <u>current</u> suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

Have you <u>recently</u> done anything to hurt yourself? □ Yes □ No

Have you had suicidal thoughts in the <u>past</u>? □ Frequently □ Sometimes □ Rarely □ Never

- If you checked any box other than "never", when did you have these thoughts?

____

- Did you ever act on these thoughts? □ Yes □ No

Have ever been the victim of, or witness to, child abuse or domestic violence? □ Yes □ No

<u>HEALTH INFORMATION AND RISK ASSESSMENTS</u>

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If currently taking medications other than the psychiatric medications mentioned above, what are they?

____

Hours per night you normally sleep _______ Are you having any problems with your sleep? □ Yes □ No

- If yes, please comment: ____

Do you exercise regularly? □ No □ Yes Comment ____

Are you having any difficulty with appetite or eating habits? □ No □ Yes

- If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Purging

Have you experienced significant weight change in the last 2 months? □ No □ Yes

Have you ever had a significant head or brain injury, concussion, whiplash, etc.? □ No □ Yes

Do you drink alcohol? □ No □ Yes

If yes, what is your frequency? □ rarely □ a few times a month □ a few times a week □ almost every day

How many drinks do you typically have when you do drink? □ 1-2 □ 3 or more

How often do you engage in recreational drug use? □ Never □ Rarely □ Monthly □ Weekly □ Daily

- If you checked any box other than "Never," which drugs do you use? ________________________________

____

Are you aware of drug or alcohol problems in your family? If so, please describe briefly: ________________________

____

OCCUPATIONAL, FINANCIAL, EDUCATIONAL, & LEGAL INFORMATION:

Highest level of education and where:____

Are you employed? □ No □ Yes

- If yes, who is your current employer/position? ____
- Are you happy at your current job (or school)? ____

Please list any work (or school) stressors, if any: ____

Do you have financial concerns? □ No □ Yes

- If yes, please explain: ____

Do you have any legal concerns? □ No □ Yes

- If yes, please explain:____

Are you currently in the military? □ No □ Yes Previously? □ No □ Yes

FAMILY AND RELATIONSHIPS:

Marital Status: □ Never Married □ Married □ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □Yes □No If yes, for how long?_________________

- If yes, on a scale of 1-10 (10=great), how would you rate the quality of your romantic relationship? ______

Do you have children? □ No □ Yes If yes, how many and their ages?: ____________________________________

Are your parents: □ still together □ divorced/separated, when____________

Mother's age_____________________Living? ___________ If deceased, when? _____________________

Father's age______________________Living? ___________ If deceased, when? _____________________

Please describe your relationship with your parents when you were growing up...and now: _____________________

____

____

Number of siblings:_______

Brothers, names and ages:____

Sisters, names and ages: ____

Do you have good family support? □ No □ Yes If yes, from whom?____

Are you aware of mental health issues in your family? Please describe briefly ___________________________________

____

<u>OTHER INFORMATION</u>:

What role, if any, do religion and/or spirituality play in your life?

What do you do that brings you joy, or helps you to care for yourself?

Is there anything that I did not ask about here that would be important for me to know about you?

How did you learn about me?