IN TAKE FORM

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

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ___ Male ___Female

Marital Status:
___ Never Married ___ Domestic Partnership ___ Married □ Separated ___ Divorced ___ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: (___) _____ May we leave a message? ___Yes ___No

Cell/Other Phone: (___) _____ May we leave a message? ___Yes ___No

E-mail: _____ 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 previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ___No ___Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? ___No ___Yes

Please list: _____

_____

Have you ever been prescribed psychiatric medication? ___No ___Yes

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? ___No ___Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ___No ___Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? ___No ___Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? ___No ___Yes

9. How often do you engage recreational drug use?

___Daily ___Weekly ___Monthly ___Infrequently ___Never

10. 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? _____

11. 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, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	List Family Member
Alcohol/Substance Abuse ___No ___Yes	_____
Anxiety ___No ___Yes	_____
Depression ___No ___Yes	_____
Domestic Violence ___No ___Yes	_____
Eating Disorders ___No ___Yes	_____
Obesity ___No ___Yes	_____
Obsessive Compulsive Behavior ___No ___Yes	_____
Schizophrenia ___No ___Yes	_____
Suicide Attempts ___No ___Yes	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? ___No ___Yes
If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ___No ___Yes
If yes, describe 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 weakness?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____