INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

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

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female

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

Number of Children: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) - May we leave a msg? □Yes □No

Cell/Other Phone: ( ) - May we leave a msg? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please be aware that email might not be confidential.

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □Yes □No

Have you had previous psychotherapy?
□No
□Yes, at Previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes
□No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?
□Yes □No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

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

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

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

6. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

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

8. Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?
□ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

_____

Have you ever experienced:

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no

Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		**Family Member**
Depression	yes/no	
Bipolar Disorder	yes/no	
Anxiety Disorders	yes/no	
Panic Attacks	yes/no	
Schizophrenia	yes/no	

Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

Client Signature: _____ **Date:** _____
(Must be over age 18 to sign)

Clinician Signature: _____ **Date:** _____
Kelley Armbruster, LISW, LLC