INTAKE FORM

Name: _____

Please fill out this form and bring it to your first session. You can use the back side if you need additional room for your answers. Information you provide here is confidential.

Today's Date: _____

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

Birth Date: _____ /_____ /_____ Age: _____

Gender: _____

Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Phone Numbers: Main Contact Phone # (Identify if Cell or Home)

_____
May we leave a message? ▫ Yes ▫ No

_____
Other contact numbers: Cell/ Home Work

May we leave a message? ▫ Yes ▫ No May we leave a message? ▫ Yes ▫ No

Note any special instructions for contacting you: _____
_____

E-mail: _____May we email you? ▫ Yes ▫ No
*Please note: Email correspondence is **not** considered to be a confidential medium of communication.

How did you hear about me?_____

If someone referred you to me, may I thank them? If so, please provide name and/ or contact phone number:

_____

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Name: _____

1. **What are your reasons for seeking therapy at this time**?

_____

_____

_____

_____

_____

_____

2. What **significant life changes or stressful events** have you experienced recently:

_____

_____

_____

_____

3. Have you previously received any type of **mental health services** (psychotherapy, psychiatric services, etc.)? ▫ No ▫ Yes

If yes, list previous therapist/practitioner(s):

_____

_____

4. Previous or Current **Diagnoses and treatment issues**:

_____

_____

5. Have you ever been **hospitalized** for a psychiatric issue? ▫ No ▫ Yes

Please explain why, when and where you got treatment:

_____

_____

_____

6. Are you **currently** taking any prescription medication? ▫ No ▫ Yes

Please list the medication names, dosage and physician who prescribed them:

_____ _____

_____ _____

_____ _____

7. Have you **recently** changed any of these medications? ▫ No ▫ Yes

Please explain: _____

8. Have you **ever** been prescribed psychiatric medication? ▫ No ▫ Yes

Please list type and provide approximate dates for previous medications:

_____ _____

_____ _____

EDUCATION AND WORK INFORMATION:

9. What is your highest level of education? _____

10. What is your occupation? _____

11. Are you currently employed outside of the home? ▫ No ▫ Yes

For how long? _____

12. If yes, who is your employer? _____

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

_____

GENERAL HEALTH, MENTAL HEALTH & ADDICTION INFORMATION

NOTE: If you become uncomfortable while completing this section please take a break and do something self-nourishing. Come back to it when you're ready.

14. How would you rate your current **physical health**? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

15. Please list any **specific health problems** you are currently experiencing:

_____

_____

16. Are you currently experiencing any **chronic pain**? ▫ No ▫ Yes

If yes, please describe

_____

and **rate your typical level of pain** on a scale of 0 to 10 with 10 being the worst pain imaginable and zero being no pain without medications:_____

17. How would you rate your **current sleeping patterns**? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

18. Please list any **specific sleep problems** you are currently experiencing:

_____

Approximate date of onset: _____

19. How many times per week do you generally **exercise**? _____
What types of exercise do you participate in?

_____

20. Have you recently gained or lost **weight**? ▫ No ▫ Yes Lost or gained? _____

How much? _____ Was it intentional? _____ How long?_____

21. Please list any difficulties with your **appetite or eating patterns**:

_____

_____

22. Have you felt fat even though others have said you are thin? ▫ No ▫ Yes

23. Have you sometimes vomited, fasted, or used laxatives or vigorous exercise in order to control your weight? ▫ No ▫ Yes

24. Are you currently experiencing **overwhelming sadness, grief or depression**? ▫ No ▫ Yes For approximately how long?: _____

Please explain what you are feeling: _____

_____

_____

25. Are you now, or have you ever attempted suicide or had suicidal thoughts?

Important: If you feel unable to keep yourself safe, please go to your local emergency room or call the Georgia Access and Crisis Line at 1 (800) 715-4225.

Please explain: _____

26. Are you currently experiencing **anxiety or panic attacks**? ▫ No ▫ Yes

If yes, when did you begin experiencing this? _____

_____

27. Do you have any **phobias** or **irrational fears**? ▫ No ▫ Yes

Please describe: _____

28. Are you **self-critical**? ▫ No ▫ Yes **Critical of others**? ▫ No ▫ Yes

29. What helps you **relieve stress**?_____

_____

_____

_____

30. Do you ever **worry** about some of the ways you relieve stress? ▫ No ▫ Yes

Explain: _____

_____

FAMILY & RELATIONSHIP INFORMATION:

31. **Relationship Status**: ▫ Never Married ▫ Domestic Partnership ▫ Married ▫ Separated ▫ Divorced ▫ Widowed ▫ Committed Relationship ▫ Single, dating ▫ Single, not dating S.O.'s name_____

32. **Sexual-Affectional Orientation:** _____

33. If you are currently in a romantic relationship, for **how long**? _____

Is your relationship exclusive or open? _____

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

Number of current sexual relationships _____

34. # of Previous marriages or serious relationships? _____

Were any of them abusive? _____

35. If single, are you satisfied with your relationship status? ▫ No ▫ Yes

36. Are you worried about your ability to be intimate? ▫ No ▫ Yes

37. How frequently have you had sex in last 6 months? _____

38. Have you or your partner had affairs? _____

39. Are you worried your significant other may have a drug/alcohol problem?

_____

40. Do you have children? ▫ No ▫ Yes If yes, list name, age, issues of concern. Please indicate if they are biological, step-children or adopted.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

41. Please tell me a little about your parents and/or who raised you. List their names and ages if they are still alive or the year of their death.

_____

_____

_____

_____

42. Please describe your family/families of origin during your childhood. Was it Happy, Stressed, Abusive, Alcoholic, etc. Are you close now?

_____

_____

_____

43. **SIBLINGS: Names, Ages and any Issues of concern:**

_____ _____

_____ _____

_____ _____

44. Do you have close friends or family from whom you can get support?

▫ No ▫ Yes Number of close connections: _____

45. Have you had any deaths in the family or among friends recently or that still feel difficult to you? Please explain:

46. Do you think you may have problems with **compulsive behaviors** or addictions in any of these areas: ▫ Sex ▫ Love/Relationships ▫ Gambling

▫ Eating ▫ Shopping ▫ Shoplifting, forgery, or fraud ▫ Lying ▫ Checking yourself

47. Do you now binge, purge or restrict food intake? ▫ No ▫ Yes

Did you ever binge, purge or restrict food intake? ▫ No ▫ Yes When? _____

48. Have you experienced any of the following?: Please Circle for Yes

Incident	**Age**	**By Whom (if applicable)**

Neglect/Abandonment

Emotional/ Verbal Abuse

Physical Abuse

Sexual Abuse/Assault

Domestic Violence

Combat

Mugging/Robbery

Serious Accident

Life Threatening Illness

Traumatic Major Surgery

Suicide Attempt(s)

Psychosis

49. Have you **perpetrated** emotional, physical or sexual violence? ▫ No ▫ Yes

Please explain: _____

50. Do you regularly lose track of time, can't remember where you are, or have gaps in your memory? ▫ No ▫ Yes When sober and drug free? ▫ No ▫ Yes

51. How often do you drink **alcohol**? ▫ Daily ▫ Weekly ▫ Monthly

▫ Infrequently ▫ Never (no alcohol ever)

52. Are you in recovery from addiction? ▫ No ▫ Yes How long? _____

What is your sobriety or clean date? _____ Have you relapsed? _____

53. What do you drink, when and how much? How many ounces per drink?

_____

_____

54. Are you or is anyone close to you concerned about your drinking?

▫ No ▫ Yes Whom? _____

55. Have you ever tried to stop drinking or stopped and resumed? ▫ No ▫ Yes
If so, when & why?_____

56. How often do you engage in recreational **drug** use? ▫ Daily ▫ Weekly ▫ Monthly ▫ Infrequently ▫ Never Which substances and how often? List.

_____

_____

_____

57. Have you ever abused **prescription drugs**? ▫ No ▫ Yes Please list.

_____

58. Are you in recovery from addiction? ▫ No ▫ Yes Attend AA/NA ▫ No ▫ Yes

If so, what is your clean and sober date? _____

59. Are you or is anyone concerned about your drug use? ▫ No ▫ Yes Whom?

_____

60. Have you ever received detox or treatment for substance abuse? ▫ No ▫ Yes

If so, where and when: _____

_____

Did you complete treatment? ▫ No ▫ Yes How long? _____

61. Have you ever been arrested for a drug or alcohol related charge? ▫ No

If yes, when and what charges? _____

Any currently pending charges or probation? _____

62. Have you ever been arrested for other reasons? ▫ No ▫ Yes

List any convictions that led to jail or prison _____

_____

BELIEF SYSTEM

63. Do you consider yourself to be spiritual or religious? ▫ No ▫ Yes

Describe your current faith, religion, or belief system: Circle all that apply

Atheist/ Agnostic/ Buddhist/ Christian/ Existentialist/ Hindu/ Humanistic/ Jewish/ Muslim/Native/ Mystical/ Pagan/ Sikh/ Taoist/ Theistic/ Non-denominational Christian/ Scientific/ Unity/ Unitarian-Universalist/ Wiccan/ None of these/ I don't know

What denomination or type? (e.g., Baptist, Orthodox, Sufi, etc.)

_____

What was the faith (if any) of your family during your childhood?

_____

Do you have negative or positive feelings about your religious upbringing?

_____

What helps you find meaning in your life?_____

_____

_____

_____

Do you struggle with feeling your life is meaningful? _____

_____

64. <u>FAMILY</u> MENTAL HEALTH HISTORY:

In the section below indicate if there is a **family** history of any of the following (not yourself.) If yes, please identify the family member's relationship to you in the space provided (sister, father, grandmother, uncle, step-mother, etc.).

<u>FAMILY</u> MENTAL HEALTH HISTORY: Any relatives have/had these? <u>Who</u>?

Please Circle yes/no If yes, please list <u>affected Family Member</u>

(Example: M, F, S, B, A, U, Maternal GM, MGF, Paternal GM, PGF)

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Bipolar Disorder yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Psychosis yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

Suicide Death yes/no

INTAKE FORM

Name: _____

PAYMENT AND EMERGENCY CONTACT INFORMATION

Please note that **you** are responsible for full payment of your fees unless previous approval and authorization has been made with your insurance carrier who may pay a portion of your fees per session.

If you have someone who is paying for your treatment:

Payor's Name & Relationship to you: (i.e., father, mother, insurance)

_____

Address & Phone # (if different from yours):_____

_____

_____

INSURANCE - I am currently accepting Blue Cross Blue Shield insurance.

Will you be using <u>in-network</u> insurance with BCBS? _____

Will you be filing for <u>out of network</u> insurance benefits with another insurance company? _____ Which one?_____

Or, will you not be filing with insurance at all? _____

EMERGENCY:

Who may I contact in case of a medical or psychological emergency?

Name & Relationship to you:

_____

Address (if different from yours):_____

_____ Phone _____

When you come in the office, I will have you sign a legal **Consent to release information form** for your emergency contact.

Thank you. I look forward to meeting and working with you. Lisa