INTAKE FORM Name: _____

Please print and complete this form before your first session. **Please** hand write and don't type in your answers, as typed in answers will not print. Information you provide is confidential. Either email with password or FAX.

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 Mobile or Home)

_____

May we leave a message? □ Yes □ No

_____

Other contact numbers: Mobile Home Work _____

May we leave a message? □ Yes □ No

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:

_____

INTAKE FORM 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 prescribing physician:

_____

_____

_____

_____

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 call 988, the Psychiatric Crisis Line or go to your local emergency room.

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? Why?

_____

_____

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 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. FAMILY MENTAL HEALTH HISTORY:

In the section below indicate if there is a known **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.).

FAMILY MENTAL HEALTH HISTORY: Any relatives have/had these? Who? Please Circle yes/no If yes, please list affected Family Member

(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.

If you have someone else who is paying for your treatment:

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

_____

Address & Phone # (if different from yours):

_____

_____

_____

INSURANCE -I am not accepting insurance but can provide you an invoice for out of network reimbursement

Will you be filing for out of network insurance benefits with an insurance company? _____ Which one?_____

EMERGENCY:

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

Name & Relationship to you:

_____

Address & Phone # (if different from yours):

_____

_____

_____

Please also sign a legal **Consent to release information form** for your emergency contact.

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

Phone 404-931-3066, FAX 855-822-7439, Email Lisawellbeing@gmail.com