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INTAKE SHEET

Client: _____**Date:**_____
Parent/Guardian Name, if client under 18:_____
Client DOB: _____ **Email Address**:_____
Telephone #: Home: _____ Work: _____ Cell: _____
Address: _____

Medical/Insurance Information
Insured Name: _____ DOB:_____ SSN:_____
Your Insurance Plan: _____ Member #: _____
Physician's Name: _____ Telephone #: _____
Physiciain's Address: _____

History
Marital Status: __Never Married, __Domestic Partner, __Married, __ Separated, __Divcd, __Widowed
Please list any children/age: _____
Have you previously received any type of **therapy** or psychiatric services? ____ No, ____Yes.
Are you **currently** taking any prescription medication? ____No, ____Yes.
Please list **meds** if yes: _____
Have you **ever** been prescribed psychiatric medication? ____No, ____ Yes.
Please list and provide dates: _____
_____

Family Mental Health History:
In the section below, please 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, aunt, etc)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive sx	yes/no	
Schizophrenia	yes/no	
Bipolar Disorder	yes/no	
Suicide Attempts	yes/no	

Presenting Problem:
Why are you seeking help? _____
_____
Are you in crisis? _____
1. How would you rate your **current physical health**? (Please circle)
Poor Unsatisfactory Satisfactory Good Very Good Excellent

Please list any health problems you are currently experiencing: _____
_____

2. How would you rate your current **sleeping** habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good Excellent

Please list any sleep problems you are currently experiencing: _____

3. How many times a week do you **exercise**: _____

What kind of exercise do you do? _____

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

5. Are you currently experiencing overwhelming sadness, grief or depression? _____
6. Are you currently experiencing anxiety, panic attacks or have any phobias? _____
7. Are you currently experiencing any chronic pain? _____
8. Do you drink alcohol more than once a week? ____Yes ____No
9. How often do you engage in recreational drug use? ___Daily, ___Weekly, ___Monthly, ___Never
10. Are you currently in a romantic relationship? _____ If yes, for how long? _____

Additional Information:

Are you currently employed? ____ Yes, ____No.
If yes, what is your current employment situation? _____
Do you enjoy your work? _____
Do you consider yourself spiritual or religious? ____Yes, ____ No.
If yes, describe your religious or spiritual belief: _____
Please describe some of your strengths: _____
Please describe some of your weaknesses: _____
Please share what you hope to get out of therapy:_____
_____

Legal:

For Minors: If parents are divorced:
Who has legal custody? _____
Who has physical custody? _____
Are there pending custody issues? _____
Are there any child abuse issues? _____
Are there any legal issues? _____

For Adults:

Have you ever been involved in domestic violence? _____
Have you ever been arrested? _____
Have you ever been sued? _____
Are you suing anyone? _____

Emergency Contact: _____