INDIVIDUAL INTAKE FORM

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Date: _____

Client Last Name:	Email Address
First Name:	Birthdate: Age:
Address: City: Zip:	Legal Guardian Name: (if under 18)
Education:	Gender: M/F
Profession:	Home Phone:
Marital Status: M/ S/D/W	Cell Phone:
Children: Y/N If yes, how old?	Emergency Contact:
Referred By:	Emergency Phone:
	Relationship to Client:

Presenting Problem/Concern:

Suicidality and Violence Assessment:

Suicidal History (date/method of attempts): _____
_____
_____

Current Risk for Suicide: ( ) None ( ) Low ( ) Medium ( ) High

Current Risk for Violence/Dangerousness ( )None ( )Low ( )Medium ( )High

General and Mental Health Information

How would you rate your current physical health?

Please list any specific health problems you are currently experiencing:

□Poor □Unsatisfactory □ Satisfactory □ Good □ Very good

_____

_____

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:

_____

_____

_____

Are you currently taking any prescription medications?

Medications	**Dosage**	**Reason**
1.		
2.		
3.		
4.		
Hospitalizations/Surgery		

How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

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

_____

_____

Do you binge/purge?. □ Yes □ No

If so, how often? _____

Are you currently experiencing overwhelming sadness, grief or depression?

□ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No □ Yes

If yes, when did you begin experiencing this?

_____

Are you currently experiencing any chronic pain?

□ No□ Yes

If yes, please describe? _____

Do you drink alcohol more than once a week? □ No □ Yes

If yes, how often? _____

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Please list any prescription and/or illegal drugs you are PRESENTLY taking that have not been prescribed by a doctor:

_____

_____

Please list any prescription and/or illegal drugs you have taken in the PAST that have not been prescribed by a doctor:

_____

_____

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, mother, sister, grandmother, uncle, etc.).

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 _____

Family Background:

Parents still living? Father ( )Yes ( )No Mother: ( )Yes ( )No

Parents: ( )Married ( )Separated ( )Divorced ( )Never Married

Siblings (Names/Ages):_____

_____

ADDITIONAL INFORMATION:

With whom are you living?

_____

Have you been married before?

_____

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?

_____

_____

What significant life changes or stressful events have you experienced recently?

Explain if any

_____

_____

_____

_____

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?

_____

_____

_____

_____

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

If yes, describe your faith or belief:

_____

_____

Previous Therapy Experiences:

_____

_____

Reason (s): _____

Therapy Expectations:

What are you expecting to get from therapy? _____

_____

Do you have any particular goals that you would like to see met in therapy?

Please Explain:_____