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INTAKE

Date:_____

Name :_____

Address:_____

Phone Number: (Home)_____ (Cell)_____(Work)_____
Best number to be reached:_____ OK to leave a message:_____ yes____no
Age:_____ Date Of Birth_____ Sex:_____M _____F
Marital Status:_____Single _____Separated _____Cohabiting _____Married
_____Divorced _____Widowed _____Other
Referred by:_____
What brings you here today?

_____
_____
_____
_____
_____
How long has this been a problem?_____
Have you been in therapy before? _____yes _____no
Dates:_____
Name of Therapist(s):_____
Phone Number(s) of Therapist (s):_____

Occupation:_____
Present Living Arrangements:_____
Recent Life Changes:_____
Have you recently suffered the loss of someone who was close to you? _____yes _____no
Have you recently suffered loss from serious social, business, or other reversals? ____yes____no
If answered yes to above questions, please explain:_____
_____
Has anyone ever forced you to do something you did not want to do? _____yes _____no
If yes, Please explain:_____
Is there any pushing, shoving, hitting, etc. in your current relationship? _____yes _____no
If yes, Please explain:_____
Have you ever been hospitalized for psychiatric reasons? _____yes _____no
If yes, Please explain:_____

Do you ever feel like or think of hurting yourself? _____yes _____no
If yes, Please explain:_____

MEDICAL HISTORY:
Current medical condition: _____good _____fair _____poor
Any current medical problems?_____
_____
Prior Hospitalizations and Surgeries:_____
_____
Any Accidents or Loss of Consciousness? _____yes _____no
If yes, Please explain:_____
List all current medications:_____
_____
_____
Name of Prescribing Physician:_____ Phone Number:_____
Any changes in eating? _____yes _____no
If yes, Please explain:_____
Any Changes in Sleep? _____yes _____no
If yes, Please explain:_____
Any Changes in Sexual Interest/Activity? _____yes _____no
If yes, Please explain:_____

FAMILY HISTORY:
Birthplace:_____
Current Family Composition:(who makes up your family?)_____
_____
_____
Names/Ages/Locations of children:_____
_____
_____
Names/Ages/Locations of parents and siblings:_____
_____
_____
Other significant relatives:_____
_____
Current relationships with family members:_____
_____
_____
Significant childhood/adolescent events:_____
_____
_____
Did you or your siblings experience childhood physical or sexual abuse? _____yes _____no
If yes, Please explain:_____
Has anyone in your family experienced domestic violence? _____yes _____no
Has anyone in your family experienced substance abuse? _____yes _____no

Does anyone in your family have a history of mental illness or psychiatric hospitalization?
____yes ____no
If yes, Please explain:_____

CHILDHOOD HISTORY:
Mother's health while pregnant with you?_____
Childhood health problems:_____
Any history of: _____nail-biting _____nightmares _____bed-wetting _____running away from home cruelty to animals _____temper tantrums _____playing with fire _____juvenile delinquency

EDUCATIONAL HISTORY:
Currently enrolled in school? _____yes _____no
If yes, list name and location of school:_____
If yes, list current grade:_____
Highest grade completed:_____ Did you drop out?_____
Do/Did you have and IEP or 504B Plan? _____yes _____no
If yes, please explain:_____
What was your behavior like in school?_____
Did you dislike school?_____ Favorite subject:_____
What kind of student were you? _____above-average _____average _____below-average
How did you get along with schoolmates?_____good _____fair _____poor
Friends?_____many _____few _____none

SOCIAL HISTORY:
Current activities and groups involved with:_____
_____
Have you ever been arrested or incarcerated? _____yes _____no
If yes, Please explain: _____

_____
Have you ever hurt or violated the rights of other people or animals? _____yes _____no

If yes, Please explain:_____

_____
Have you ever served in the Military? _____yes _____no
Are there any gaps in your employment history? _____yes _____no
If yes, Please explain:_____
Religious/Spiritual Affiliation:_____
Social/Recreational Interests:_____

CIGARETTES, ALCOHOL AND DRUGS:
Do you smoke? _____yes _____no Age when started? _____

How much? _____
Do you currently or have you in the past drank alcohol? _____yes _____no
Age when started? _____
Frequency of drinks (number): _____ day _____week _____month ___ no current use
Do you drink: _____socially _____weekends _____alone _____at work _____other
Do You Feel Drinking is a Problem? _____yes _____no
If yes, Please explain:_____
What is your feeling about alcohol? _____enjoy it _____is relaxing _____depressing
makes you sleep pass out forget things giggly get in fights
Do you currently or have you in the past used any drugs? _____yes _____no
Age when started?_____
What drugs do you use?_____
Frequency of use: _____daily _____weekly _____monthly _____ no current use
Do you use drugs: _____socially _____weekends _____alone _____at work
_____other
Do You Feel Using Drugs is a Problem? _____yes _____no
If yes, Please explain:_____
What is your feeling about drugs? _____enjoy it _____is relaxing _____depressing
makes you sleep pass out forget things ___giggly _____get in fights
Have you ever been to a Rehab Program? _____yes _____no
Did you Complete the Program? _____yes _____no If yes, when? _____
What is your longest period of Sobriety?
_____