

Intake Information

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Completing this form will take you about 45 minutes though will likely be a useful process for you in clarifying what you want from therapy so that I can understand earlier in our work. I ask you to take the time to complete it and bring it with you to your scheduled session. You might want to glance through it before beginning to complete it.

Note: Complete all pertinent questions: If you are single, please disregard the couple related questions. (Do include notes of divorces, remarriages, location of family, who is supportive or critical of you and who are each of your children most like.)

TODAY'S DATE: _____

YOUR INFORMATION:

Your Name: _____

Nationality: _____ Religion: _____

Your Age: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Mobile Phone: _____ Email Address: _____

Other Additional Phone Number(s) _____

Profession: _____

Number of Years married to your current spouse: _____

Previous marriages(s) & length of each marriage: _____

Previously Experienced Therapy/Counseling (circle one) Y or N Was it helpful? Y or N

Insurance Provider: _____ (circle- Yes or No) Do you intend to file with your insurance provider to reimburse you for a portion or all of your cost for therapy?

Emergency Contact: _____ Phone Number: _____

Relationship: _____

SPOUSE'S (OR IF YOU ARE A YOUTH-PARENT'S) INFORMATION

Spouse's or Parent's Name: _____

Nationality: _____ Religion: _____

Age: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Mobile Phone: _____ Email Address: _____

Profession: _____

Previous marriages(s) & length of each marriage: _____

Children and other Members of the Family/Household:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YOUR FAMILY OF ORIGIN:

Mother's Name: _____ Nationality: _____

Religion: _____

Age: _____ Health _____

Location: _____ Profession: _____

Write 3 adjectives to describe your Mother:

Father's Name: _____ Nationality: _____

Religion: _____

Age: _____ Health _____

Location: _____ Profession: _____

Write 3 adjectives to describe you Father:

CURRENT PROBLEMS/ISSUES- I ask each of you attending the session to include a one page summary giving me a description and background information of the current problems and issues you want to address as well as your wishes for this course of therapy. If you wish you may use a separate piece of paper and attach it to this document.

INDIVIDUAL'S SYMPTON CHECKLIST

Please rate the severity of any current or recent symptoms.

Absent= 0(or leave blank) **mild= 1 moderate= 2 severe= 3** don't know= ?

For the first day of therapy date and complete the left hand column of symptoms. (The other columns are for later updates.)

DATE CHECKED: _____	DATE CHECKED: _____
Headache _____	phobias _____
Shortness of Breath _____	Unpleasant dreams _____
Dizziness _____	Missing blocks of time _____
Feeling Faint _____	Impaired memory _____
Trembling _____	Feeling unreal _____
Shaking _____	Difficulty making friends _____
Sweating _____	Difficulty making decisions _____
Heart Pounding _____	Experiencing unreasonable anger _____
Rapid Heartbeat _____	Difficulty Controlling Impulses _____
Chest Pain _____	Feeling too energetic _____
Nausea _____	Frequently making poor decisions _____
Constipation _____	Low self-esteem _____
Diarrhea _____	Depressed Mood _____
Poor Appetite _____	Feeling helpless _____
Weight Loss _____	Feeling worthless _____
Weight Gain _____	Feeling guilty _____
Nervousness _____	Feeling tired _____
Fearful for no reason _____	Loss of energy _____
Feeling panic _____	Loss of interest or pleasure _____
Difficulty sleeping _____	Poor concentration _____

(Circle: getting to, staying, early waking)

Family Health Checklist

Check all that apply to each family member and to yourself:

	You	Spouse	Child/Children	Briefly Explain
Anxiety:				
Depression:				
Excessive Alcohol Use:				
Substance Abuse:				
Excessive Anger:				
Excessive Working:				
Over or Under Eating:				
Excessive spending/Gambling				
Obsessive Sexual Behavior:				
Previous Hospitalizations:				
Currently taking Medications				
Physical conditions or Impairments				