INTAKE FORM

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Please provide the following information and answer the questions below to the best of your ability and bring it to your first session. The information you provide in this form is protected as confidential information.

Name: ____

Parent/Caregiver____

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Please list children and their ages: ____

Address: ____

____

Home Phone: _____________________________________ May we leave a message? □ Yes □ No

Cell/Other Phone: __________________________________May we leave a message? □ Yes □ No

E-mail: ____May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

What are the problem(s) for which you are seeking help?

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What are your treatment goals?

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Current Symptoms Checklist. If applicable, please provide a short description on the lines below.

Abuse, trauma, neglect: emotional ( ) physical ( ) sexual ( ) spiritual ( ) ________________________________

Chronic pain, chronic illness, complex medical challenges, disabilities ( )______________________________

Death and dying, end of life, unfinished business ( ) ____

Existential crises, finding meaning and purpose ( ) ____

Fear, dread, torment ( ) ____

Grief, loss, sadness, regret ( ) ____

Guilt, shame, condemnation ( ) ____

Inner healing ( ) ____

Interpersonal communication and relationships ( ) ____

Self-development and identity ( ) ____

Depressed mood ( ) Racing thoughts ( ) Excessive worry ( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks ( ) Sleep pattern disturbance ( ) Increase risky behavior ( ) Avoidance ( ) Loss of interest ( ) Hallucinations ( ) Concentration/forgetfulness Suspiciousness or paranoia ( ) Change in appetite ( ) Excessive energy ( ) Increased irritability ( ) Fatigue ( ) Crying spells ( ) Decreased libido ( )

Suicide Risk Assessment: Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? ____

When was the last time you had thoughts of dying? ____

Has anything happened recently to make you feel this way? ____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____________

Would anything make it better? ____

Have you ever thought about how you would kill yourself? ____

Is the method you would use readily available? ____

Have you planned a time for this? ____

Is there anything that would stop you from killing yourself? ____

Do you feel hopeless and/or worthless? ____

Have you ever tried to kill or harm yourself before? ____

Do you have access to guns? If yes, please explain. ____

Have you ever been psychiatrically hospitalized? ( ) yes ( ) no If yes, list place, date, and reason for hospitalization.

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Have you ever been in outpatient treatment? ( ) yes ( ) no If yes, list place, dates, and reason for treatment.

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List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Dosage/Amount

____

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Alcohol use ___________________________ Drug use ____________________________________

Current over-the-counter medications or supplements: _______________________________________

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Current medical problem(s): ____

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Does anyone in your family experience mental health problems? ____________________________

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What do you consider some of your strengths? ____

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Thank you for completing this form.