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Intake Form

Please share with me whatever information you feel might be helpful in our work together. Your answers will remain confidential.

Name: _____Date:_____

Address: _____Date of Birth: _____

Birth Time: _____ Birth City: _____

Phone: Home:_____Work:_____Cell: _____

Please place an asterisk next to numbers where I can leave a confidential voice mail.

Would you like to receive appointment reminders here?Y ____N ____

Email Address (Is this a private email?): _____

Emergency Contact (Name and Phone Number): _____

Referred By:_____

Chief Concern

Please describe the main concern that has brought you to see me:

_____

_____

_____

_____

_____

General Health

How would you rate your current physical health?

Poor ____ Unsatisfactory ____ Satisfactory ____ Good ____ Excellent ____

How would you rate your current sleeping habits?

Poor ____ Unsatisfactory ____ Satisfactory ____ Good ____ Excellent ____

How many times a week do you generally exercise?_____

What types of exercise do you participate in?_____

_____

Please describe any difficulties with your weight, appetite, or eating patterns: _____

_____

_____

Please detail your **current** and **chronic** medical issues/ challenges (use back of form if necessary for medical history and prescription information):

_____

_____

Please list **prescriptions** and **over-the-counter** medications and dosages.

_____

Your medical care team: Doctors' name(s)/ Phone numbers:

_____

If you enter treatment with me, may I communicate with your medical doctor(s) to coordinate your treatment?Yes____N ____Maybe____(Within Limits)

Spiritual Y / N
What does spirituality mean to you?

_____

Religion Y / N
If yes, what religion?

_____

Traumas:

_____

_____

_____

Childhood and Education

Briefly describe your family of origin (parents, siblings, etc.) and your childhood:

_____

_____

_____

Did you have serious illnesses/ injuries **OR** physical/ emotional trauma as a child?

_____

_____

_____

Education Details: _____

_____

Occupation/ Previous Occupation(s): _____

Employer: _____ Length of time with this employer: _____

Present Relationships

Are you in a current relationship? Yes____ No ____

If yes, how do you get along with your spouse or partner? _____

_____

Do you have children/ grandchildren? Yes____ No ____

If yes, what are their ages? _____

How do you get along with your children/ grandchildren? _____

_____

Briefly describe ***any other*** important relationships in your life. Are you satisfied with how they are going?

_____

_____

_____

Past Psychological/ Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?Yes ____No ____

Please indicate which type of treatment: Inpatient ____Outpatient ____Both ____

If yes, please indicate details:_____

_____

_____

Have you ever taken medications for psychiatric or emotional problems?Yes ____No ____

If yes, please indicate type, duration, results: _____

_____

_____

Do you have a **family history** of psychological/ psychiatric disorders?Yes ____No ____

If yes, please describe:_____

_____

_____

Have you been suicidal in the past month?Yes ____No ____

Have you ever had thoughts of taking your life?Yes ____No ____

Have you ever acted on these thoughts?Yes ____No ____

If yes, please describe what happened: _____

_____

_____

Has anyone in your family taken their own life or attempted suicide?Yes ____No ____

If yes, please describe:_____

_____

_____

_____

Please check any of the following that have been bothering you lately:

	Abused as Child		Agoraphobia		Alcohol Use
	Ambition		Anger		Anger Management
	Anxiety/ Stress		Appetite		Being a Parent
	Bladder/ Bowel Issues		Career Choices		Children
	Compulsions		Compulsivity		Concentration
	Confidence		COVID-19 Fears		COVID-19 Losses
	COVID-19 Recovery		Depression		Divorce
	Drug Use/ Abuse		Eating Problem(s)		Education
	Energy (High/ Low)		Extreme Fatigue		Family Member (Dementia)
	Fears/ Phobias		Feeling Suicidal		Finances
	Friends		Grief		Guilt
	Headaches		Health Problems		Inferiority Feelings
	Insomnia		Loneliness		Making Decisions
	Marriage		Memory		Nervousness
	Nightmares		Obsessive Thinking		Overweight
	Painful Thoughts		Panic Attacks		Physical Pain
	Relationships		Sadness		Self-Esteem
	Self-Harm (Cutting, etc)		Separation		Sexual Problems
	Short Temper		Shyness		Sleep
	Suicidal Thoughts		Weight Issues		Work

Please indicate (check) how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Use the following scale:

1. No Effect
2. Little Effect
3. Some Effect
4. Much Effect
5. Significant Effect
6. Doesn't Apply

Areas of Life Effected	1 No Effect	2 Little Effect	3 Some Effect	4 Much Effect	5 Significant Effect	6 Doesn't Apply
Marriage/ Relationship						
Family						
Job/ School Performance						
Friendships						
Financial Situation						
Physical Health						
Anxiety Level						
Mood						
Eating Habits						
Sleeping Habits						
Sexual Functioning						
Alcohol/ Drug Use						
Ability to Concentrate						
Ability to Control Anger						

Substance Use

Do you currently consume alcohol? Yes____No ____

If yes, on average how many drinks per occasion do you consume?_____

How many days per week do you consume alcohol?_____

Do you have a history of problematic use of alcohol?Yes____No ____

Have family members or friends expressed concern about your drinking?Yes____No ____

Do you currently use non-prescribed drugs or street drugs?Yes____No ____

Do you have a history of problematic use of prescription or non-prescription drugs?
Yes____No ____

Do you have a family history of alcohol/ drug problems?Yes____No ____

If yes, please describe:_____

Do you smoke or use other tobacco products?Yes____No ____

If yes, would you like help in quitting smoking?Yes____No ____Perhaps____

Do you feel that you are in danger?Yes____No ____

If yes, please explain: _____

_____

More About You

What normally brings you joy?_____

Have you recently had difficulty experiencing that sense of joy?Yes____No ____

How would you describe important aspects of your cultural/ ethnic identity that would be important for me to consider as your psychologist?

_____

_____

What do you consider your greatest strengths/ sources of resilience?_____

_____

_____

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms?

Please tell me here; use the back of the paper if needed.

Please complete and send this intake form along with other required forms to info@elevateyoursoul.org