

INTAKE FORM

*Please provide the following information. If something does not apply to you, please write N/A. Your answers to these questions enable me to more effectively and efficiently understand your experience. **Please note: Information you provide here is protected as confidential information.***

Please print out and complete this form and fax it to me at 408-904-5186. If this is not possible, you may bring it with you to your first session.

Name: _____ Date: _____

Address:

Number and Street	City/State/Zip
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Home Phone: _____ OK to leave discreet message? Yes No

Cell/Other Phone: _____ OK to leave discreet message? Yes No

**Please note: Email correspondence is not considered to be a confidential medium of communication, and so I do not use email in my practice.*

Age: _____ Birth Date: _____

Marital Status: _____ Educational level: _____

Occupation: _____

Please list children/name/age. Grandchildren?

Who lives at home with you? Pets?

Person to contact in case of emergency (name and phone):

How were you referred to me?

Please tell me why you are seeking psychotherapy now

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalization due to mental health emergency, etc.)?

- No
- Yes, previous therapist (name and approximate dates)/hospitalization. Please indicate focus of treatment and/or diagnoses.

2. How would you rate your current physical health? (please circle)
Poor Fair Good Very Good Excellent
Please list any specific health problems you are currently experiencing:

3. Have you ever been diagnosed with a serious physical/medical illness or condition?
No Yes. Please describe:

4. How would you rate your current sleeping habits? (please circle)
Poor Fair Good Very Good Excellent

Please list any specific sleep problems you are currently experiencing:

5. What types of physical exercise do you participate in?

6. Please list any difficulties (past/current) you experience with your appetite, eating patterns, or other eating issues:

7. Are you currently experiencing overwhelming sadness, hopelessness, depression, or irritability? No Yes

If yes, for approximately how long? And, any identifiable reason/s:

8. Have you ever attempted suicide? No Yes. Please describe the circumstances that led to the attempt.

9. Are you currently experiencing persistent worry, anxiety, panic attacks, or have any phobias?

No Yes. When did you begin experiencing this? Please note any reasons, if known:

10. Please list all prescription medication, for what purpose, dosage, and date began:

Who prescribes your medication/s (for example, a psychiatrist or general physician)? Please include name/s of practitioner/s.

Over the counter medication (purpose, dosage and date began):

11. How much caffeine do you drink/day?

12. Do you smoke cigarettes, and/or use nicotine patches or gum? No Yes

If yes, please describe frequency and quantity:

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13. Do you drink alcohol? No Yes

If yes, please indicate what kind, how often, and how much:

14. Other drug use (including prescription drugs not prescribed to you).

For each substance, please indicate how often and how much:

15. Have you, *or someone close to you*, ever felt you had a problem with alcohol or other drugs? No Yes. Please describe:

FAMILY OF ORIGIN HISTORY:

1. In the section below, identify if there is a family history of any of the following issues. If yes, please indicate the family member’s relationship to you in the space provided (father, stepmother, grandmother, uncle, etc.):

<i>Please circle yes or no:</i>		List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Bipolar/manic-depression	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____
Suicide Completion	yes/no	_____

2. Please describe your relationship with your father. If deceased, please indicate your age at time of his death.

3. Please describe your relationship with your mother. If deceased, please indicate your age at time of her death.

4. Please list siblings names/ages and describe relationship with each:

5. Please describe any trauma experienced by you or your family member/s while growing up : abuse (physical, verbal, sexual), physical illness, addiction, accident, divorce, death

ADDITIONAL INFORMATION:

1. How do you enjoy your work (inside or outside the home)/school? Is there anything stressful about your current work?

2. Are you currently in a romantic relationship (include current long-term relationship).

No Yes. For how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Are there any issues involving your relationship that you would like to focus on in therapy? No Yes. Please describe:

3. Please describe your spiritual or religious orientation:

4. What do you consider to be some of your strengths?

5. Please describe your hobbies or interests:

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

7. How do you cope with stress?

8. Please include any other information that you believe is relevant to your mental health treatment, not previously addressed.

9. Please tell me what you would like to accomplish out of your time in therapy.
