Psychotherapy Intake Form

Demographic Information:

Name____

Address____

____

Home Phone: (   ) ____________________________________
May we leave a message? ❑ Yes ❑ No

Cell/Other Phone: (   ) ____________________________________
Is it okay to send a text message? ❑ Yes ❑ No

Email: ____
May we email you? ❑ Yes ❑ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birthdate ____

Gender Identity/Preferred Pronouns ____

Relationship Status ____

Employment Status____

Student Status ____

Referred by ____

Insurance information:

Primary Insurance
Company____
ID# ____
Group# (if applicable) ____
Insurance Company Billing Address (on back of card):
____
____

Subscriber's Name ____________________________________

Subscriber's Address ____

Subscriber's Date of Birth ____________________________________

Relationship to Patient ____

Secondary insurance company (if applicable) _________________________________
ID# ____
Group# ____

General health and mental health information:

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good

Please list any special health problems you are currently experiencing:
____
____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good

Please list any special sleep problems you are currently experiencing:
____
____

3. How many times per week do you generally exercise? ______
What types of exercise do you participate in?
____

4. Please list any difficulties you experience with your appetite or eating patterns:
____
____

Would you consider these indicative of an eating disorder? _________________________________

5. Are you currently experiencing sadness, grief, or depression? ❑ Yes ❑ No
If yes, for approximately how long?
____

6. Are you currently experiencing anxiety or panic attacks? ❑ Yes ❑ No
If yes, when did you begin experiencing this? ____

7. Are you currently experiencing any chronic pain? ❑ Yes ❑ No
If yes, please describe:
____
____

8. Have you ever experienced a traumatic event? ❑ Yes ❑ No
If yes, please describe (if comfortable):
____
____
____

9. Are you currently taking any prescription medication? ❑ Yes ❑ No
Please list: (or attach separate sheet)

____
____
____
____

10. Have you ever been prescribed medication for psychological symptoms (for example: anxiety, depression, etc.)? ❑ Yes ❑ No
Please list and provide dates:

____
____
____
____

11. Do you drink alcohol more than once a week? ❑ Yes ❑ No

12. How often do you engage in recreational drug use?
❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

13. Are you currently in a romantic relationship? ❑ Yes ❑ No

14. What significant life changes or stressful events have you experienced recently:

____
____
____
____

15. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
❑ No ❑ Yes - Previous therapist/practitioner:

____

Family mental health history:

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

Alcohol/Substance Abuse	yes	no	____________
Anxiety	yes	no	____________
Depression	yes	no	____________
Domestic Violence	yes	no	____________
Eating Disorders	yes	no	____________
Obesity	yes	no	____________
Obsessive/Compulsive Behavior	yes	no	____________
Schizophrenia	yes	no	____________
Suicide Attempts	yes	no	____________

Additional information: ____
____

Work Information:

Are you currently employed? ❑ Yes ❑ No
What is your current employment situation?
____
____
____

Do you enjoy your work? Is there anything stressful about your current work?
____
____
____

Additional Information:

What do you consider to be some of your strengths?
____
____
____
____
____

What do you consider to be some of your challenges?
____
____
____
____
____

What would you like to accomplish in therapy?
____
____
____
____
____