Individual Intake Date_____

Name_____DOB_____

Address_____Gender M F

Home Phone _____Cell Ph_____ Work Ph _____

Okay to leave a message? _____ Email _____

Referred by _____Primary physician _____

Emergency contact number _____ Relationship? _____

Highest Education Level _____ What did you study? _____

Currently in School? _____ Where? _____ Studying? _____

Employer _____ Occupation_____

Length of employment _____ Any problems? _____

Partner's Employer _____

What issues/concerns cause you to seek treatment? Please describe: _____

_____

_____

_____

Do you have any specific goals with regard to your treatment? _____

_____

_____

Have you experienced any of the following symptoms:
____Thoughts of Suicide ____ Work Problems ____ Depression ____Anxiety
____ Relational Problems ____Anorexia/Bulimia ____Self harm ____Trauma
_____Problems with intimacy _____School Problems _____ Legal Problems
_____Violence ____Financial problems _____ Drug abuse___Alcohol problems
____ Sexual/Physical/Emotional abuse _____Arrests Other_____

Relationship status:____single _____married _____divorced ____widowed ____cohabitating _____separated How long in current relationship? _____
Describe the quality of your relationship _____

Number of children _____ Names, Gender & Ages _____
_____

Difficulties conceiving? _____Miscarriages?/# _____
Stillbirths?/# _____ Abortions?/# _____ Deaths? _____

Primary support system: _____

Other significant relationships: _____

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother: _____

_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father: _____

Relationships with step-parents: _____

Names, ages and relationship with siblings: _____

_____

In-Laws: _____

Have you ever been diagnosed with a serious physical or mental illness?_____

Describe_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress- related condition? Please describe. _____

_____

Do you have a family history of mental, emotional or substance abuse problems?

_____

Have you received mental health treatment before? _____In/outpatient?____

Name of Therapist(s)	Dates (from when to when)	Reason	Outcome
_____	_____	_____	_____
_____	_____	_____	_____

Have you participated in psychological testing? _____With whom_____

Have you ever been hospitalized for mental or emotional problems? Describe circumstances _____

Are you currently taking any prescription medications? List medications, dosage, and how long you have been taking the medication: _____

_____

Prescribed by whom and for what condition?_____

Any herbal/over-the-counter medications?_____

Have you ever attempted suicide? When?_____

Describe the circumstances that led to that attempt _____

_____

_____

Are you currently having any suicidal thoughts? Please describe. _____

_____

Please describe your childhood. _____

_____

Have you ever been subjected to verbal abuse _____physical abuse_____

Sexual abuse _____domestic violence_____ By whom?_____

Describe _____

Have you ever been a victim of a violent crime?_____ Type _____

Have you ever witnessed a violent crime or terrifying event?_____Type_____

Currently using drugs besides those prescribed by a doctor? ___In past?_____

If yes, which drugs and how much? _____

In a support group/12-step program? _____Attendance freq_____

Do you smoke? _____How much? _____For how long? _____

Do you drink alcohol? _____ If yes, how much per day/week?_____

Are you now or have you ever been involved in a lawsuit?_____ Please describe.

Describe diet and exercise_____

Any behaviors feel out of control?_____

Describe the role of religion or spirituality in your life: _____

Describe your interests/hobbies _____

Describe your strengths _____

How have you attempted to solve problems or change behaviors?_____

SUMMARY_____
