

INTAKE INFORMATION

DATE: _____

NAME: _____ **DOB:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

TELEPHONE NUMBERS:

(H) _____ **(W)** _____ **(C)** _____

ACCEPTABLE TO CONTACT YOU AND LEAVE A MESSAGE ON: (circle)

HOME PHONE Y N CELL PHONE Y N WORK Y N

HOME MAIL Y N EMAIL Y N (email not a guaranteed secure mode)

INSURANCE COMPANY: _____

I.D. _____ **GROUP #:** _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ **TELEPHONE:** _____

CURRENT FAMILY SITUATION: (partners, spouses, children, roommates, extended family) _____

INITIAL COMPLAINT OR CONCERN: _____

DATE PROBLEM/CONCERN BEGAN: _____

BRIEF HISTORY OF THE PROBLEM/COMPLAINT: _____

PREVIOUS THERAPY FOR THE PROBLEM/COMPAINT **YES** **NO**
IF YES, DATE(S) AND BRIEF DESCRIPTION. WAS IT HELPFUL?

CURRENT SYMPTOMS: (please describe on reverse if indicated)

- sleep problems eating problems concentration difficulties
- loneliness moody sad angry irritable anxious
- hopelessness panic attacks cycling repetitive thoughts
- recurring bad dreams weight changes: _____
- increase in unhealthy or self harming behaviors: _____
- suicidal thoughts/wishing you were dead: _____
- decrease in ability to have fun or enjoy typical pleasurable activities:
- increase in physical discomfort/pain: _____
- changes in relationship(s) with family, friends, work: _____

ANY OTHER COMPLAINTS/PROBLEMS: _____

RECENT IMPORTANT EVENTS/CHANGES IN LIFE OR LIVES OF SIGNIFICANT OTHERS: _____

CURRENT MEDICAL CONDITION/CONCERNS: _____

PHYSICIAN(S) AND CONTACT NUMBERS:

MEDICATIONS—PRESCRIBED AND OVER THE COUNTER:

Medication/Condition:	Amount:	Prescriber:
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

HOSPITALIZATIONS:

year: _____ **cause:** _____ **outcome:** _____

(additional information can be written on the back of this sheet)

RELATIONSHIP HISTORY (relationships/years/marriages/divorces/domestic partnerships): (Please continue on other side.)

SUBSTANCE USE—ALCOHOL, DRUGS/STREET OR PRESCRIBED:

started at age: _____ (alcohol) _____ drugs

frequency: _____ type(s): _____

history and changes in use: _____

problems or complaints: _____

treatment (year/setting): _____

CURRENT SOURCES OF REJUVENATION, RELAXATION, PLAY:

GOAL(S) FOR THERAPY: _____

WHEN WILL YOU KNOW THAT THERAPY IS COMPLETED?

Client signature

Date