

## INTAKE FORM

Please fill out this form and bring it to your first consultation session. You may use the back of this page if necessary.

*Please note: information you provide here is protected as confidential information.*

**NAME:** \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

\_\_\_\_\_  
(Last) (First) (Middle Initial)

**ADDRESS:** \_\_\_\_\_  
(Number and Street Name)

\_\_\_\_\_  
(City) (State) (Zip)

PHONE [H]: \_\_\_\_\_ May I leave a message?  Yes  No

PHONE [C]: \_\_\_\_\_ May I leave a message?  Yes  No

E-MAIL: \_\_\_\_\_ May I email you?  Yes  No

*\*Please note: Email correspondence is not considered to be a confidential medium of communication.*

**BIRTH DATE:** \_\_\_/\_\_\_/\_\_\_ **AGE:** \_\_\_\_\_ **GENDER :**  Male  Female  \_\_\_\_\_

**RACIAL IDENTITY:** \_\_\_\_\_ **ETHNIC IDENTITY:** \_\_\_\_\_

### MARITAL STATUS:

Never Married  Domestic Partnership  Married  
 Separated  Divorced  Widowed  Other

Please list any children/age:

\_\_\_\_\_  
\_\_\_\_\_

Referred by (if any): \_\_\_\_\_

Emergency Contact: (name) \_\_\_\_\_ (phone#) \_\_\_\_\_

**May I contact this person in case of a medical emergency?**  Yes  No

### INSURANCE INFORMATION

Insurance name: BCBC HMO BCBS PPO other: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Check here to authorize use of your insurance plan and submission of claims to the plan stated above.**

PT: \_\_\_\_\_

CONFIDENTIAL INFORMATION

## HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalization, day treatment etc.)?  No  Yes, previous therapist/practitioner:

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Are you currently taking any prescription medication?  Yes  No

Please list:

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Have you ever been prescribed psychiatric medication?  Yes  No

Please list and provide dates:

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## 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 specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits? (please circle)

Poor    Unsatisfactory                      Satisfactory                      Good                      Very good

Please list any specific sleep problems you are currently experiencing:

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3. How many times per week do you generally exercise? \_\_\_\_\_ How long? \_\_\_\_\_

What types of exercise do you participate in?

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

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5. Are you currently experiencing overwhelming sadness, grief, or depression?

No  Yes

If yes, for approximately how long? \_\_\_\_\_

Any thoughts of self-harm, suicide or harm to others?  No  Yes

If yes, for approximately how long? \_\_\_\_\_

Are you currently experiencing mood swings, racing or disorganized thought patterns?  No  Yes

If yes, for approximately how long? \_\_\_\_\_

PT: \_\_\_\_\_

CONFIDENTIAL INFORMATION

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

No  Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

How does your anxiety manifest? \_\_\_\_\_

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

\_\_\_\_\_

8. Do you drink alcohol more than once a week?  No  Yes If yes, how many drinks do you consume a week? \_\_\_\_\_

9. How often do you engage in recreational drug use?

Daily  Weekly  Monthly  Infrequently  Never

Please describe use: \_\_\_\_\_

10. Are you currently in a romantic relationship?  No  Yes

If yes, for how long? \_\_\_\_\_

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

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

\_\_\_\_\_

12. Have you witnessed any violence, trauma or loss? Please describe:

\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY:**

In the section below, 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.).

*Please circle*

*List Family Member(s)*

	<i>Please circle</i>	<i>List Family Member(s)</i>
Alcohol/Substance Abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Anxiety/ Panic Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Depression/ Bipolar	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Domestic Violence	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Eating Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Obesity	<input type="checkbox"/> No <input type="checkbox"/> Yes	
OCD	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Schizophrenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Suicide Attempts	<input type="checkbox"/> No <input type="checkbox"/> Yes	

PT: \_\_\_\_\_

**CONFIDENTIAL INFORMATION**

Trauma/ PTSD	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Adoption	<input type="checkbox"/> No <input type="checkbox"/> Yes	
ADHD/ ADD	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Developmental Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Autism Spectrum Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Behavioral Issues	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Gender Identity	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Personality Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**ADDITIONAL INFORMATION:**

1. Are you currently employed or in school?  No  Yes If yes, what is your current employment/school situation?

\_\_\_\_\_

Do you enjoy your work?  No  Yes

Is there anything stressful about your current work/school situation?

\_\_\_\_\_

Have you served in the military?  No  Yes Division \_\_\_\_\_ Rank \_\_\_\_\_ Years served \_\_\_\_\_  
Military experience? \_\_\_\_\_

2. Do you consider yourself to be spiritual or religious?  No  Yes If yes, describe your faith or belief:

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. What would you like to accomplish out of your time in therapy?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Is there any additional information you would like to share that would better understand you or your needs for therapy at this time?

\_\_\_\_\_

\_\_\_\_\_