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INTAKE FORM

Date_____

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. I work with a variety of people so some information may not pertain to you. Please fill out this form to the best of your ability and comfort and bring it to your first session. Thank you so much.

Name:

_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____

E-mail: _____ Phone _____

May I email you? □Yes □No

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

Home Address:_____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: ( ) May I leave a message? □ Yes □ No

Cell/Other Phone: ( ) May I leave a message? □ Yes □ No

How do you identify your gender: _____

How would you describe your sexual orientation: _____

What would you like me to know anything about your sexual orientation or interests?

_____

Relationship Status: □ Never Married □ Domestic Partnered □ Married □ Separated

□ Divorced □ Widowed # of times Married_____

Current Partner_____ age_____

Please list any children/age(s): _____ _____

_____ _____ _____

Are you currently employed outside the home? □ No □ Yes

If yes, what is your current employment situation and position:

_____

How did you find me?

□ website _____ □ personal referral □ professional referral

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

_____ dates _____

Are you currently taking any medication-including psychiatric meds? □ Yes □ No

Please list: _____

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 issues you currently have:

_____

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:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

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

_____

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

□ No □ Yes If yes, for approximately how long?_____

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

□ No □ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain or chronic illness?

□ No □ Yes If yes, please describe? _____

7a. Do you take yoga, meditate or other mindful practice? What?_____

8. How many times do you drink in a week? _____None □

9. How often do you engage recreational drug use? Types?_____

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Have you ever had your thyroid checked?

□ No □ Yes If yes, what was the result? _____

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RELATIONSHIP HISTORY AND STATUS

How might you identify at this time? (circle all) *monogamous / in an open relationship / does not apply at this time/ Other*

Are you currently in a relationship? □ No □ Yes How long? _____

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

How OFTEN are you INTERESTED in being sexual? _____times week/ month (circle)

How often are you sexual with yourself? _____ With others_____

On a scale of 1-10, how satisfied are you with your sexual interests and activities _____

On a scale of 1-10, how confident are you in your ability to bring pleasure to your partner?

___ How confident are you in your ability to receive pleasure from your partner?_____

What role does sexuality play in your life? _____

_____

How satisfied are you with the amount you know about sex and sexuality? _____

FAMILY OF ORIGIN: Father _____age___ Mother_____ age___

Siblings/names/ages_____

Anything noteworthy regarding your family of origin?_____

_____

Where were you raised?_____

What religion or spiritual teachings were you raised with? _____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your current faith or belief: _____

ADDITIONAL INFORMATION:

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

_____

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

_____

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.). If any of these apply to you, please feel free to write "self" in the*

Please Circle List	Self	Family Member
Alcohol/Substance Abuse yes/no	____	_____
Anxiety yes/no	____	_____
Depression yes/no	____	_____
Sexual Abuse 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	____	_____
Self-injury (cutting, scratching, other)	____	_____

OPTIONAL:

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

_____

_____

_____

_____

5. What do you consider to be some of your challenges?

_____

_____

_____

_____

6. What would you like to accomplish out of your time here?

_____

_____

_____

_____

7. If you could change anything about yourself, what would it be?

_____

_____

_____

_____

8. Anything else you would like me to know?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____