Initial Intake Form

Personal Information

Name

Address

City State ZIP Date of Birth

Home Phone Cell phone

Preferred e-mail address

Any ways that you **do not** want to be contacted ☐ email ☐ phone ☐ cell phone

---

Emergency Contact Phone #

Relationship to you

Family Background

Spouse or Significant Other

Children (and ages)

Parents or Step Parents

Siblings

Any family issues that may be presently impacting your situation

Please describe any counseling or psychiatric treatment you have received in the past:

Please describe any treatment you have received for substance abuse:

Please list any past or current physical health issues, surgeries, or injuries:

Please list any medications you taking (Prescribed or non-prescription). Please include any holistic herbs or medicines.

Are you now, or have you ever taken any psychotropic medications (i.e.; anti-anxiety, antidepressants, antipsychotic, or mood stabilizers)?

- ○ Yes
- ○ No

Please indicate any of the conditions below you have experienced:

- ☐ Severe Anxiety
- ☐ Frequent or severe headaches
- ☐ Loss of interest/pleasure in doing things
- ☐ Feeling down, depressed or hopeless
- ☐ Change in sleep habits
- ☐ Difficulty concentrating
- ☐ Noticeable sluggishness, fatigue or loss of energy
- ☐ Noticeable restlessness or fidgeting
- ☐ Thoughts of suicide or suicide attempts
- ☐ Panic attacks
- ☐ Excessive worry or anxiety
- ☐ Muscle tension, aches or soreness (not related to physical exertion)
- ☐ Trouble falling asleep or staying asleep
- ☐ Becoming easily annoyed or irritable
- ☐ Verbal or physical aggression
- ☐ Marked change of appetite (either increased or decreased)
- ☐ Racing thoughts

- ☐ Excessive energy or activity level
- ☐ Recurrent and persistent thoughts or images
- ☐ Repetitive behaviors/“checking”
- ☐ Inability to control or excessive control over what or how much you eat
- ☐ Drinking alcohol against medical advice
- ☐ Legal/work/school difficulties due to alcohol consumption/hangover
- ☐ Use of alcohol/drugs to control mood
- ☐ DUI
- ☐ Relationship problems
- ☐ Violence within family and/or relationships
- ☐ Illegal drug use
- ☐ Dizziness or fainting spells
- ☐ Significant weight gain or loss
- ☐ Head injury
- ☐ Loss of or erratic menses
- ☐ Family history of mental health issues
- ☐ Family history of drug/alcohol abuse
- ☐ Been the victim of violence or assault
- ☐ Sexual difficulties
- ☐ Learning difficulties or skipping required classes, poor study skills, difficulty with test taking, inability to study with groups or independently, etc

Please describe:

Thank You!