Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

*If you feel there are certain questions you do not yet feel comfortable answering at this time, please mark these questions with an (*) and we can review these when needed and appropriate.

Name:_____

Name of parent/guardian if under age 18:_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: ▫ Male ▫ Female Marital Status:

▫ Never Married ▫ Domestic Partnership ▫ Married ▫ Separated ▫ Divorced ▫ Widowed

Please list any children/age: _____

Address:

_____

_____

Phone:_____ Best way and time to reach you:_____

Email:_____

May I leave a phone message? ▫Yes ▫No May I email you? ▫Yes ▫No

Referred by (if any):_____

Please describe what prompted you to make this appointment:

_____

_____

_____

_____

_____

_____

Please check all the behaviors and symptoms that are a problem for you, and note length of time that these have been happening. Do your best and we can discuss any concerns further.

Symptoms:

__ Significant weight change
__ Feelings of worthlessness
__ Guilt/shame

__Indecisiveness
__ Self Harm (i.e., cutting, burning)
__ Wishing you didn't exist
__ Recurrent thoughts of death
__ Have a plan for suicide
__ Attempted suicide and number of times___
__ Want to hurt others/or have
__ Loss of joy doing things you loved
__ Irritability
__ Excessive anger
__ Social Withdrawal
__ Less Productive
__ Seasonal mood changes
__ Excessive talking
__ Restless, can't sit still
__ Flight of ideas
__ Racing thoughts
__ Feelings of grandiosity/ have super powers
__ Great increase in energy, activity
__ Wide mood swings
__ Difficulty maintaining employment

__ Nausea
__ Dizziness
__ Feelings that you aren't real
__ Chills
__ Can't relax
__ Worry about things over and over
__ Panic
__ Day dreaming
__ Disorganization
__ Lack of follow through
__ Distractibility
__ Difficulty putting thoughts together

__ Flashbacks of previous trauma
__ Nightmares
__ Re-experiencing trauma
__ Pushing loved ones away

__ Sleeping in excess
__ Recurring disturbing memories
__ Numbing
__ Constantly on alert
__ Difficulty leaving the house

__ Startle easily
__ Avoidance
__ Memory lapses
__ Intrusive thoughts, impulses you can't control
__ Same thoughts over
__ Repetitive behaviors
__ Obsessive compulsive behaviors

__ Racing heart
__ Sweating, shaking
__ Chest pain, shortness of breath
__ Somatic symptoms

__ Interrupting
__ Overly active
__ Told you are intrusive
__ Hearing voices others don't see/being told to do things to self or others
__ Seeing things that don't exist
__ Feeling that someone that only you see is watching you

__ Problems with pornography

__ Careless mistakes
__ Losing objects/forgetful
__ Low frustration tolerance
__ Restricting food
__ Compulsive/binge eating
__ Purging/laxatives/ extreme exercise
__ Body dissatisfaction
__ Desire to be very thin

__ Gambling
__ Computer addiction
__ Shopping/spending excessive money
__ Parenting problems
__ Substance abuse
__ Becoming abusive towards others
__ Parenting problems
__ Relationship problems
__ Other/please describe

Which of the above symptoms are most concerning to you?_____

_____

_____

Previous Mental Health & Substance Abuse Treatment:

Medication prescribed for Mental Health:_____

Psychiatric Hospitalizations:_____

Substance Abuse Treatment (inpatient & outpatient:_____

Substance Abuse Supports: (i.e., AA, NA):_____

Substance Use History

Substance	Age when 1st used	Most used in one time	Current Use	Last time used	If use stopped, why?
Caffeine					
Nicotine					
Alcohol					
Amphetamine (speed, uppers)					
Depressants (xanax, klonopin)					

Substance	Age when 1st used	Most used in one time	Current Use	Last time used	If use stopped, why?
Inhalants (whip-its, paint, glue)					
Marijuana (pot, weed)					
Narcotics (Vicodin, Oxycotton, Percocet, heroin)					
Cocaine (blow, crack)					
Methamphetamine (meth, crank, ice, glass, crystal)					
Ecstasy					
Other					

When you drink, do you drink to get drunk? Yes No N/A

Have you ever blacked out from alcohol/drug use? More than 3 times? Yes No N/A

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?_____

How has substance use effected your life? Both in the past and present._____

_____

Do you have other medical issues? If so please explain_____

_____

Entering Counseling:

1) How are these problems interfering with your life?_____

_____

_____

_____

2) What do you want to work on first?_____

_____

3) What are your expectations on how long it should take to accomplish this? _____

_____

4) What would you like to come out of us working together? _____

_____

5) What have you tried thus far to address this problem?_____

_____

6) What do you think has stopped or is stopping you from successfully addressing this problem?

_____

_____

_____

Religious/Spiritual Beliefs

Childhood and Current Beliefs:_____

To what degree do spiritual and religious beliefs impact you?_____

_____

_____

Is there anything else you feel that is important for me to know?_____

_____

_____

_____

_____

Thank you for your time & honesty with this paperwork.