

Intake Form

Please provide the following information and answer the questions below. *For couples or families, you may fill out only one form if preferred.

Name:

Last _____ First _____ DOB: ____ / ____ / ____ Age: ____
Last _____ First _____ DOB: ____ / ____ / ____ Age: ____
Last _____ First _____ DOB: ____ / ____ / ____ Age: ____

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

Last _____ First _____ DOB: ____ / ____ / ____ Age: ____

Marital Status:

- Never Married Domestic Partnership Married Separated
 Divorced Widowed

Please list any children and age _____

Address _____ **City** _____ **PC** _____

Contact Information:

Home Phone: (_____) _____ May I leave a message? Yes No
Cell/Other Phone: (_____) _____ 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.

Referred by (if any) _____

Hours of Availability:

Monday	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm
Tuesday	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm
Wednesday	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm
Thursday	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm
Friday	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm
Other	_____											

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
- Yes, previous therapist/practitioner _____

Are you currently taking any prescription (including psychiatric) medication?

- No
 - Yes
- Please list _____
-

Have you ever been prescribed psychiatric medication?

- Yes
 - No
- Please list and provide dates _____
-

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 _____

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?

- No
- Yes

If yes, please describe? _____

8. Have you experienced a traumatic brain injury?

- No
- Yes

If yes, please describe? _____

9. Have you experienced or are you currently experiencing events that you consider to be mentally, emotionally, and / or physically traumatic?

- No
- Yes

If yes, please describe? _____

10. How often do you consume alcohol? Daily Weekly Monthly
 Infrequently Never

On average, how much alcohol do you consume when you drink? 1 drink 2 drinks
 more than 2 drinks

11. How often do you engage recreational drug use? Daily Weekly Monthly
 Infrequently Never

12. Are you currently in a relationship?

- No
- Yes

If yes, for how long? _____

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

13. Please list any significant life changes or stressful events that you have 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.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	

Eating Disorders	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Suicide Attempts	yes/no

Other conditions _____

Additional Information

1. Are you currently employed? No Yes

If yes, what is your current employment situation? _____

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

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 areas for improvement?

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

Financial Policy

Outstanding Accounts

It is expected that clients either pay weekly *before* each session or pre-pay for a number of sessions at one time. Missed payments will lead to the suspension of counselling services until payment in full has been made. Feel free to ask any questions.

Cancellation Policy

48 hours notice is required for all cancellations.

Late cancellations or “no-shows” will have the per-session fee added to their account. Clients with two “no-shows” risk having their counselling suspended or terminated.

Your signature below indicates that you have read and understood the information contained in this financial policy. If there is any portion of this policy that requires further explanation please be sure to make this clear to your counselor before signing the document.

I have read and understand the above information and agree to abide by the information herein.

Signature _____ Date _____

Signature _____ Date _____