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INTAKE FORM

Contact Information

Name _____ **Date** _____ **DOB** _____

Address _____

Home number _____**Can I call you here?** ____**Can I leave a message?** _____

Cell number _____**Can I call you here?** ____ **Can I leave a message?** ____

e-mail address _____
Name of emergency contact _____ **Relationship** _____

Phone number _____ **Cell emergency number** _____

Alternative emergency contact _____ **number** _____

Who referred you? _____

People who support you	**Relationship**	**Location**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Information

Name of personal physician & phone number _____
If necessary, I will contact your physician.
_____

When was your last doctors appointment? _____
Please list any past medications and their effectiveness:

Please list any current medications, their effectiveness, and dosage (including herbal):

Please list current medical problems or physical complaints:

Have you ever been hospitalized for physical or mental health issues? If yes, please explain.

Please list any allergies:
How often, if ever, do you drink alcohol & how much is consumed per occasion?

Do you have a history of problem drinking, drugs or any addiction? Yes_____ No_____

If yes, please briefly explain and list which "drug", how much, and how often:

Have you ever been in the military?

Psychological Information

Please circle any of the following struggles that pertain to you:

Anxiety Grief Depression Fears/Phobias Work/Stress Cutting/Self-mutilation

Sexual Problems Suicidal Thoughts Separation/Divorce Health problems Concentration

Relationships Finances Drug/alcohol use Anger Internet/Computer Thought Patterns

Career choices Self-control Body Image/food Sleeping Problems Religious matters

Please list major life events/illnesses/traumas & the year of each:

What is your goal for therapy or how will your life/heart be when you no longer need therapy?