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INSTRUCTIONS FOR FILLING OUT FORMS

The questions you will find on these forms are helpful in your treatment.

The more I understand about your history and your personal situation, the more I will be able to help you.

However, if you find some of them too uncomfortable, feel free not to answer them.

These forms take time and effort on your part. Completing them outside of your appointment time will enable you to talk about your more immediate concerns during your appointment.

INTAKE FORM

Today's Date: _____

Personal Information

Name:

Age:

Sex:

Date of Birth: / / Home Phone #: ( ) -

Cell Phone #: ( ) -

Full Address:

Marital Status: (please check one)

Never Married: ___

Married: ___

Divorced: ___

Widowed: ___

Separated: ___

Other:___

City: State: Zip:

Message Phone #: ( ) -

# of Children: Their Ages: Home Phone #: ( ) -

Emergency Contact Person: Their Phone #: ( ) -

Education / Employment Information

Last grade completed in school:

Are you employed now? Yes No

Present Occupation:

Company Name:

Main occupation during past 5 years:

Religious Affiliation:

Do you currently attend a place of worship?: Yes No

General Information

How did you hear about me?

_____

Problems you want help with:_____

_____

_____

_____

_____

How much have you worked during the past two years?

_____

Describe your education (# of years of school, special training, etc.):

_____

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, etc.):

_____

_____

_____

Describe your living situation:

_____

Did anyone in your family die before you were 18 years old? Yes No

Who? How old were you? _____

Other family deaths?

When were you last examined by a physician? Name _____

Present physician's name _____ Phone number _____

List any major health problems for which you have received treatment: _____

_____

Do you or your family members currently have or have ever had any of the following: (Please check

all that apply)

SELF FAMILY

HEART PROBLEMS..... _____

CANCER..... _____

NERVOUS BREAKDOWN _____

STROKE _____

CHRONIC ILLNESS _____

ALCOHOL OR DRUG ABUSE _____

LEGAL PROBLEMS _____

LEARNING DISABILITY _____

DEPRESSION _____

OTHER _____

List any medications you are now taking (prescription and non-prescription): _____

Have you been abused or assaulted? YES NO DON'T REMEMBER (Circle One) YES NO DON'T REMEMBER

Did you witness abuse between your parents? YES NO DON'T REMEMBER (Circle One)

Did you witness abuse between parent and child? YES NO DON'T REMEMBER (Circle One) YES NO DON'T REMEMBER

Have you ever received psychiatric or psychological help or counseling of any kind before?

YES NO

If you have, please
explain:_____

List everyone currently living in your home, including family and other:

NAME

AGE

BIRTHDATE

RELATIONSHIP

Please circle any of the following which concern you:

NERVOUSNESS

DEPRESSION

FEARS

SHYNESS

SEXUAL PROBLEMS

SUICIDAL THOUGHT

SEPARATION

DIVORCE

FINANCES

ANGER

SELF-CONTROL

FRIENDS

SLEEP PROBLEMS

STRESS

WORK/SCHOOL

RELAXATION

HEADACHES

TIREDNESS

LEGAL MATTERS

MEMORY

AMBITION

ENERGY

INSOMNIA

MAKING DECISIONS

LONELINESS

INFERIORITY

FEELINGS

CONCENTRATION

EDUCATION

CAREER CHOICES

MARRIAGE/RELATIONSHIPS

HEALTH PROBLEMS

TEMPER

NIGHTMARES

CHILDREN

EATING PROBLEMS

UNHAPPINESS

SEXUAL ABUSE

PHYSICAL ABUSE

BOWEL TROUBLES

BEING A PARENT

MY THOUGHTS

STOMACH PROBLEMS

GAMBLING

BINGE EATING

EATING TOO LITTLE

TOO HEAVY OR THIN

SPIRITUALITY

UNFORGIVENESS

Please circle any of the following strengths you have:

CONFIDENT

HARD WORKER

ORGANIZED

SYMPATHETIC

GOOD LISTENER

DEPENDABLE

SENSITIVE

LOGICAL

LOYAL

GRACIOUS

DECISIVE

RESPONSIBLE

UNDERSTANDING

SENSE OF HUMOR

PATIENT

OTHER

Please use the list below to describe your use of drugs. Answer “yes” or “no” for each drug listed, and if “yes”, answer the remaining questions.

No, I Never Used

Yes, I Used

If yes, age at first use

If yes, when using, frequency of use (daily, weekly, etc.)

If yes, how long since last used?

Tobacco

Alcohol

Marijuana/Hashish

Cocaine

Crack

Meth/Amphetamine/Speed

Opiates (Pain Pills, Heroin, Morphine)

Hallucinogens (LSD, Mushrooms, Mescaline, etc.)

Inhalants

Xanax/Valium (Other Sedatives)

Sleeping pills

Ecstasy/Molly

K2/Spice

Other designer drugs/club drugs/research chemicals

Other drugs not listed

Please use the list below to describe any impulsive behaviors. Please answer "Yes" or "No" and then follow the questions asked for substances if "Yes."

Eating too much

Eating too little

Binging and Purging

Gambling

Pornography

Video Games

Day Trading

Internet Sites

Please add any additional information which you feel may be helpful to me:
_____

_____
_____

_____
_____

THANK YOU FOR FILLING OUT THIS FORM

_____

Client's Signature

_____

Date