

Initial Therapy Intake Form

The information you provide here is confidential, per the standards outlined in the Terms of Service.

Today's Date

Personal Information:

Full Name

Age

Birth Date

Home Phone

Work Phone

Cell Phone

May I say who I am if I phone you?

Yes

No

Is it okay to leave you a message at the above phones?

Yes

No

E-mail address

Mailing Address

City

State

Zip

Emergency Contact/Name

Phone

Primary goals of Therapy

- 1.
- 2.
- 3.

Why are you seeking therapy at this time?

What specific things do you want to see changed in your life?

What specific question(s) would you like your therapist to help you answer?

What steps have you already taken to improve your situation?

Any other additional comments or information you would like your therapist to know about you or your situation:

Select Any of the Following That May Apply to You or Your Family:

You

Mother/Father
Siblings

Grandparents
Aunts & Uncles

Headaches
Heart Palpitations
No Appetite
Over-Eating
Anorexia
Bulimia
Stomach/Bowel
Fatigue
Insomnia
Unable To Relax
Hallucinations
Anxiety/Panic Attacks
Fears and Phobias
Obsessions
Depression
Suicidal Ideas/Attempts
Psychosis, Schizophrenia
Bipolar Disorder
Cutting
Use of Tranquilizers/Pain Meds
Alcohol/Drug Abuse
Learning Disorders
ADD/ADHD/Hyperactivity
Hospitalizations
Severe Illness
Homosexual
Heterosexual
Bisexual
Sexual problems
Low self esteem
Shy with people
Difficulty making friends
Always worried about something
Don't like weekends/vacations
Difficulty making decisions
Financial or legal problems
Gambling
Job problems
Difficulties at home
Other

Select any of the following you have experienced in the past 12 months

- Difficult or painful sexual intercourse
- Premenstrual tension
- Menopause
- Nightmares
- Flashbacks of unpleasant events
- Recurrent grinding thoughts
- Anxiety or panic attacks, fear of places, events
- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Being hyper-alert, sensitive to sights and or sounds
- Constant struggle to keep "bad thoughts" away
- Avoiding activities that evoke memories
- Diminished interest in usual activities
- Feeling detached and removed
- Feeling numb inside
- Crying spells
- Overeating, vomiting, using laxatives
- Grinding teeth
- Thoughts of ending your life
- History of attempted suicide
- Accidents
- Depression
- Loss of energy, feeling apathetic
- Loss of sexual interest or desire
- Loss of sexual functioning
- Feeling "blue," disinterested in usual things
- Difficulty concentrating
- Poor memory
- Difficulty making decisions
- Excessive perspiration
- Buying impulsively
- Stealing small or large items from stores
- Heavy use of alcohol or drugs
- Loss of memory for particular times or events

Lifestyle and habits

Education

What is your occupation?

Do you enjoy your job?

Relationship Status:

Single

Married

Separated

Divorced

Committed Relationship

Living Arrangement:

Alone

With Spouse/Boyfriend/Girlfriend/Partner

With Roommate

With Family

Religion

Number of close friends who you confide in

Recreation/Hobbies

Special diets

Exercise

Number of beers

per day

per week

per month

Number of glasses of wine

per day

per week

per month

Number of hard liquor drinks

per day

per week

per month

Use of tranquilizers/pain pills

per day

per week

per month

Use of marijuana

per day

per week

per month

Cigarettes

Yes

No

per day

of years you have smoked

Coffee, tea, soft drinks

Yes

No

cups/bottles per day

Medications (list all the drugs you have taken in the last year)