

Intake Form

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

Please fill out this form and bring it to your first session.

GENERAL INFORMATION

Date: _____

Name: _____

Address: _____

Home phone: _____ Cell phone: _____

OK to leave a detailed message: Yes ___ No ___ Which phone? _____

Email address: _____

May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

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

(Last) (First) (Middle Initial)

Age: _____ Occupation: _____ Sex: ___ M ___ F

Date of birth: _____ Place of birth: _____ Religion: _____

Insurance information:

Name of Primary insurance holder _____

DOB of Primary insurance holder _____

Name of Insurance Company: _____

Insurance ID: _____

Insurance phone number from insurance card: _____

Name of family physician: _____ Phone: _____

By whom were you referred: _____

Intake Questions:

Marital status: single engaged married separated

divorced widowed living with someone remarried

Do you live in: house room apartment other: _____

With whom do you live? self only parents spouse roommate

child(ren) friend(s) other (specify): _____

What kind of work do you do now? _____

Does your present work satisfy you? Yes No

If no, please explain: _____

What kind of work have you done in the past: _____

Have you been in therapy before ? Yes No

Have you ever been hospitalized for psychological/psychiatric problems? Yes No

If yes, when and where? _____

Have you ever attempted suicide? Yes No

If yes, circumstances: _____

Does any member of your family suffer from an “emotional” or ”mental disorder”?

Yes No

Has any relative attempted or committed suicide? Yes No

PERSONAL AND SOCIAL HISTORY

Father’s age: _____

If deceased, age at time of death _____ How old were you? _____

Cause of death: _____

Mother's age: _____

If deceased, age at time of death _____ How old were you? _____

Cause of death: _____

Siblings: Age(s) of brother(s): _____

Age(s) of sister(s) : _____

Any significant details about siblings : _____

Were you raised by your parents?:(if not, by whom): _____

Description of your relationship with your father: _____

Description of your relationship with your mother: _____

In what ways were you punished or disciplined by your parents: _____

Impression of home atmosphere in which you grew up (including compatibility between parents and children) : _____

Are (were) you able to confide in your parents: ____ Yes ____ No

Do (did) you feel loved and respected by your parents? ____ Yes ____ No

If you have a stepparent, give your age when your parent remarried: _____

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc?

____ Yes ____ No

If yes, please describe: _____

Last grade in school completed (or highest degree): _____

DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your main problem(s): _____

On the scale below, please estimate the severity of your problem(s):

____ mildly upsetting ____ moderately upsetting ____ severe ____ very severe

____ totally incapacitating

When did your problem(s) begin: _____

What seems to worsen your problem(s)? _____

What have you tried that has been helpful? _____

How satisfied are you with your life as a whole at the present?

Not at all satisfied 1 2 3 4 5 6 7 Very satisfied

How would you rate your overall level of tension during the past month?

Relaxed 1 2 3 4 5 6 7 Tense

EXPECTATIONS REGARDING THERAPY

In a few words, what do you think therapy is all about? _____

How long do you think therapy should last? _____

What personal qualities do you think the ideal therapist should possess? _____

THOUGHTS

What do you consider to be your craziest thought or idea? _____

Are you bothered by thoughts that occur over and over again? ___ Yes ___ No

If yes, what are those thoughts? _____

What worries do you have that may negatively affect your mood or behavior? _____

INTERPERSONAL RELATIONSHIPS

Friendships

Do you make friends easily? ___ Yes ___ No Do you keep them? ___ Yes ___ No

Did you date much during high school? ___ Yes ___ No College? ___ Yes ___ No

Were you ever bullied or severely teased? ___ Yes ___ No

Describe any relationship that gives you:

Joy: _____

Grief: _____

Rate the degree to which you generally feel relaxed and comfortable in social situations:

Very relaxed 1 2 3 4 5 6 7 Very anxious

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts? ___ Yes ___ No

Marriage (or committed relationship)

How long did you know your spouse before your engagement? _____

How long were you engaged before you got married? _____

How long have you been married or together? _____

What is your spouse's age _____ His/her occupation? _____

Describe your spouse's personality: _____

What do you like most about your spouse? _____

What do you like least about your spouse? _____

What factors detract from your marital satisfaction? _____

On the scale below, please indicate how satisfied you are with your marriage or long-term relationship:

Very dissatisfied 1 2 3 4 5 6 7 Very satisfied

How do you get along with your partner's friends and family?

Very poorly 1 2 3 4 5 6 7 Very well

How many children do you have? _____

Names and ages: _____

Do any of your children present special problems? Yes No

If yes, please describe: _____

Any significant details about a previous marriage(s) or relationship(s)? _____

Sexual Relationships

Describe your parents' attitude toward sex. Was sex discussed in your home? _____

When and how did you derive your first knowledge of sex? _____

When did you first become aware of your own sexual impulses? _____

Have you ever experienced any anxiety or guilt arising out of sex or masturbation?

Yes No

If yes, please explain: _____

Any relevant details regarding your first or subsequent sexual experiences? _____

Is your present sex life satisfactory? Yes No

If no, please explain: _____

Provide information about any significant homosexual reactions or relationships:

Please note any sexual concerns not discussed above: _____

Other Relationships

Are there any problems in your relationships with people at work? Yes No

If yes, please describe: _____

Please complete the following:

One of the ways people hurt me is: _____

I could shock you by: _____

My spouse (boyfriend/girlfriend) would describe me as: _____

My best friend thinks I am: _____

People who dislike me: _____

Are you currently troubled by any past rejections or loss of a love relationship? ___ Yes ___ No

If yes, please explain: _____

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? ___ Yes ___ No

If yes, please specify: _____

Please list any medications you are currently taking: _____

Do you eat three well-balanced meals each day? ___ Yes ___ No

Do you get regular physical exercise? ___ Yes ___ No

If yes, what type and how often? : _____

Please list any significant medical problems that apply to you or to members of your family:

- Unhappy childhood School problems Severely bullied or teased
 Emotional/behavioral Problems Financial problems Eating disorder
 Legal trouble Strong religious convictions
 Death in family Drug use

Others: _____

BEHAVIORS

- Overeat Loss of control Phobic avoidance Crying
 Take drugs Suicidal attempts Spend too much money
 Unassertive Compulsions Can't keep a job
 Odd behavior Smoke Insomnia
 Drink too much Withdrawal Take too many risks
 Work too hard Nervous tics Lazy
 Procrastination Concentration difficulties Outbursts of temper
 Impulsive reactions Sleep disturbance Eating problems

Others: _____

FEELINGS

Check any of the following feelings that often apply to you:

- Angry Fearful Happy Hopeful Bored Optimistic
 Annoyed Panicky Conflicted Helpless Restless Tense
 Sad Energetic Shameful Relaxed Lonely
 Depressed Envious Regretful Jealous Contented
 Anxious Guilty Hopeless Unhappy Excited

___ Others: _____

PHYSICAL SYMPTOMS

Check any of the following physical sensations that often apply to you:

- ___ Abdominal pain ___ Bowel disturbances ___ Hear things ___ Blackouts
___ Tingling ___ Watery eyes ___ Numbness ___ Flashes
___ Headaches ___ Stomach trouble ___ Nausea ___ Hearing problems
___ Dizziness ___ Tics ___ Palpitations ___ Fatigue
___ Dry mouth ___ Muscle spasms ___ Twitches ___ Tension
___ Back pain ___ Chest pain ___ Tremors ___ Rapid heart beat
___ Unable to relax ___ Fainting spells ___ Don't like to be touched
___ Burning or itching skin ___ Skin problems ___ Excessive sweating
___ Menstrual difficulties ___ Pain or burning with urination ___ Visual disturbances
___ Sexual disturbances Others: _____

IMAGES

Check any below that you have thought about or felt recently:

- ___ Being happy ___ Being talked about ___ Being trapped
___ Being hurt ___ Being aggressive ___ Being laughed at
___ Not coping ___ Being helpless ___ Being promiscuous
___ Succeeding ___ Hurting others ___ Losing control
___ Being in charge ___ Being followed ___ Failing
___ Others: _____

Describe any persistent or disturbing images that interfere with your daily functioning:

Do you have nightmares? ___ yes ___ no

If so, how often: _____

THOUGHTS you may have or have had about yourself:

___ Intelligent ___ A nobody ___ Inadequate ___ Concentration difficulties

___ Confident ___ Useless ___ Confused ___ Memory Problems

___ Lazy ___ Evil ___ Worthwhile ___ Untrustworthy

___ Ugly ___ Attractive ___ Dishonest ___ Ambitious

___ Crazy ___ Stupid ___ Sensitive ___ Can't make decisions

___ Naïve ___ Loyal ___ Considerate ___ Morally degenerate

___ Honest ___ Deviant ___ Incompetent ___ Good sense of humor

___ Worthless ___ Unlovable ___ Conflicted ___ Undesirable

___ Persevering ___ Suicidal ideas ___ Trustworthy ___ Full of regrets

___ Unattractive ___ Horrible thoughts ___ Hard Working

THOUGHTS continued

On each of the following items, please circle or underline the number that most accurately reflects your opinions.

Key: 1 = strongly agree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree

I should not make mistakes. 1 2 3 4 5

I should be good at everything I do. 1 2 3 4 5

When I do not know something, I should pretend that I do. 1 2 3 4 5

I should not disclose personal information. 1 2 3 4 5

I am a victim of circumstances.	1	2	3	4	5
My life is controlled by outside forces.	1	2	3	4	5
Other people are happier than I am.	1	2	3	4	5
It is very important to please other people.	1	2	3	4	5
Play it safe; don't take any risks.	1	2	3	4	5
I don't deserve to be happy.	1	2	3	4	5
If I ignore my problems, they will disappear.	1	2	3	4	5
It is my responsibility to make other people happy.	1	2	3	4	5
I should strive for perfection.	1	2	3	4	5
Basically, there are two ways of doing things – the right way and the wrong way.	1	2	3	4	5
I should never be upset.	1	2	3	4	5

Check any of the following that apply to you:

	Never	Rarely	Occasionally	Frequently	Daily
Muscle weakness					
Tranquilizers					
Diuretics					
Diet pills					
Marijuana					
Hormones					
Sleeping pills					
Aspirin					
Cocaine					
Pain killers					
Narcotics					
Stimulants					
Hallucinogens					
Laxatives					
Cigarettes					
Tabacco (specify)					
Coffee					
Alcohol					
Birth control pills					
Vitamins					
Under eat					
Over eat					
Eat junk foods					
Diarrhea					
Constipation					
Gas					
Indigestion					
Nausea					
Vomiting					
Heartburn					
Dizziness					
Palpitations					
Fatigue					
Allergies					
High blood pressure					
Chest pain					
Shortness of breath					
Insomnia					
Sleep too much					
Fitful sleep					
Early morning wakening					
Earaches					

	Never	Rarely	Occasionally	Frequently	Daily
Headaches					
Backaches					
Bruise or bleed easily					
Weight problems					
Others:					

STRUCTURAL PROFILE

Directions: Rate yourself on the following dimensions on a seven-point scale with “1” being the lowest and “7” being the highest.

BEHAVIORS Some people may be described as “doers” – they are action oriented, they like to busy themselves, get things done, take on various projects. How much of a doer are you? _____

FEELINGS Some people are very emotional and may or may not express it. How emotional are you? How deeply do you feel things? How passionate are you? _____

PHYSICAL SENSATIONS Some people attach a lot of value to sensory experiences, such as sex, food, music, art, and other “sensory delights”. Others are very much aware of minor aches, pains and discomforts. How “tuned into” your sensations are you? _____

MENTAL IMAGES How much fantasy or daydreaming do you engage in? This is separate from thinking or planning. This is “thinking in pictures”, visualizing real or imagined experiences, letting your mind roam. How much are you into imagery? _____

THOUGHTS Some people are very analytical and like to plan things. They like to reason things through. How much of a “thinker” and “planner” are you? _____

INTERPERSONAL RELATIONSHIPS How important are other people to you? This is your self-rating as a social being. How important are close friendships to you, the tendency to gravitate toward people, the desire for intimacy? The opposite of this is being a “loner”. _____

**BIOLOGICAL
FACTORS**

Are you health and health conscious? Do you avoid bad habits like smoking, too much alcohol, drinking a lot of coffee, overeating, etc.? Do you exercise regularly, get enough sleep, avoid junk foods, and generally take care of your body? _____

STRUCTURAL PROFILE

In the space next to each of the following items, please write down the number that most accurately reflects your opinion.

Strongly Disagree	Moderately disagree	Slightly disagree	neutral	Slightly agree	Moderately agree	Strongly agree
1	2	3	4	5	6	7

- ___ I tend to plan things and think about them a great deal.
- ___ I often imagine situations “in pictures.”
- ___ In making a decision, I often let my feelings and emotions determine what I should do.
- ___ Basically, I’m in excellent health.
- ___ I can form clear mental pictures.
- ___ I get sufficient rest and relaxation.
- ___ I would probably be described as “active and energetic”.
- ___ I would *not* be described as a “loner”.
- ___ I am a very active person.
- ___ I follow good nutritional habits.
- ___ Most of the time, I’d rather be with other people than alone.
- ___ I often engage in intellectual (cognitive) activities.
- ___ I can form vivid pictures in my imagination.
- ___ I avoid overeating, too much alcohol, and keep away from harmful things such as drugs and tobacco.
- ___ I am tuned in to my senses – what I see, hear, taste, smell and touch.
- ___ Friendships are very important to me.
- ___ I consider myself sensual and sexual.
- ___ I usually think before acting.
- ___ I am aware of the ways in which my senses react to different stimuli.

- ___ I am an imaginative person.
- ___ I have very deep feelings and notions.
- ___ I reason most things out quite thoroughly.
- ___ I keep busy doing things.
- ___ I think more in pictures than in words.
- ___ I take good care of my body.

In the space next to each of the following items, please write down the number that most accurately reflects your opinion.

Strongly Disagree	Moderately disagree	Slightly disagree	neutral	Slightly agree	Moderately agree	Strongly agree
1	2	3	4	5	6	7

- ___ I keep occupied and on the go.
- ___ I pay a lot of attention to my feelings and emotions.
- ___ I have several close or intimate friendships.
- ___ I focus a great deal on my bodily sensations.
- ___ I am a very emotional person.
- ___ I analyze things quite thoroughly.
- ___ My feelings are easily aroused and/or changeable.
- ___ I am full of pep and vigor.
- ___ Most of my five senses are very keen (smelling, tasting, seeing, hearing, touching).