INTAKE ASSESSMENT

Name: Date of initial visit:

Home address:

Date Of Birth: Age: Marital Status: Gender:
Employer:
Referred by:

Home phone: Work phone:
Cell phone: Email Address:

Name of Spouse/Significant Other:
Phone:

Members of Family/Household: Age: Relationship:
1.
2.
3.
4.
5.

INSURANCE INFORMATION

Name of Insured:
Date of Birth: SS#
Relationship To Patient:

Insurance Carrier:
Address:

Phone number for insurance questions:

ID# Group#

Primary Care Provider:
Address:

Phone:

Are you currently receiving psychiatric services or professional counseling?
□No
□Yes, Current psychiatrist or therapist's name: Phone:

Have you had previous psychotherapy?
□No
□Yes, Previous therapist's name:

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No

If Yes, please list medications and dosages:

Who is the prescribing doctor?

If no, have you been previously prescribed psychiatric medication?
□Yes □No

If Yes, please list medications, length of time taken, and most recent date taken:

Have you ever been hospitalized for any mental health related concerns?
□Yes □No

If Yes, please describe:

Release Of Information

I authorize the release of my medical or other information necessary to process this claim

Signature_____Date_____

I authorize payment of medical benefits directly to the provider

Signature _____ Date_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good

2. Please list any persistent physical symptoms or health concerns
(e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____

5. Are you having any difficulty with appetite or eating habits?
□ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more
□ Binging □ Restricting □ Purging

Have you experienced significant weight change in the last 2 months?
□ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 3 or more drinks in a 24- hour period?
_____

7. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?
□ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship? _____

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

10. In the last year, have you experienced any significant life changes or stressors? If so, what are they?

11. Have you ever experienced any of the following:
Extreme depressed mood yes/no
Wild mood swings yes/no
Rapid speech yes/no
Severe anxiety yes/no
Panic Attacks yes/no
Phobias yes/no
Sleep disturbances yes/no
Hallucinations yes/no
Unexplained losses of time yes/no
Unexplained memory lapses yes/no
Alcohol/substance abuse yes/no
Frequent body complaints yes/no
Eating disorder yes/no
Body image problems yes/no
Repetitive thoughts (obsessions) yes/no
Repetitive behaviors (frequent checking) yes/no
Homicidal thoughts yes/no
Suicide thoughts and/or attempt yes/no
Traumatic memories/flashbacks yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position?

If yes, are you happy at your current position?

Please list any work-related stressors, if any:

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression yes/no	
Bipolar Disorder yes/no	
Anxiety Disorders yes/no	
Panic Attacks yes/no	
Schizophrenia yes/no	
Alcohol/Substance Abuse yes/no	
Eating Disorders yes/no	
Learning Disabilities yes/no	
Trauma History yes/no	
Suicide Attempts yes/no	

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What symptoms or problems are you presently experiencing?

What are your goals for therapy?