

Meagan Rae Segal, LCSW-R
1055 Stewart Avenue Suite 2B
Bethpage NY 11714
(516) 903-9624

Meagan@letchangebegintherapy.com
www.LetChangeBeginTherapist.com

Intake Form

Demographic Information:

Patient Name: _____

Address: _____

Who resides with you at this address? _____

Birth Date: _____ Age: _____

How do you identify? _____

Are you in a relationship, if so with whom? _____

Do you have children? If yes, please list _____

Phone Number: () _____

In case of an emergency, who should be contacted? _____

How did you hear about me? _____

Insurance Information:

Insurance Company (Name/ID #) _____

General Health and Mental Health Information:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? _____

If Yes, previous therapist/practitioner/experience/diagnosis:

Are you currently taking any prescription psychiatric medication? _____

If Yes, please list _____

Have you ever been hospitalized for a psychiatric reason? _____

If yes, please describe

Please list any specific health problems you are currently experiencing or have been diagnosed with:

Are you currently taking any prescription medication for a medical reason _____

If Yes, please list _____

Are you currently taking any vitamins and or natural supplements _____

If Yes, please list _____

Please list any significant past illnesses or injuries including hospitalizations/surgeries:

How often do you drink alcohol? _____

How often do you engage recreational drug use? _____

Have you ever been treated for alcohol and or substance abuse? _____

If yes, please list

How would you describe your childhood?

Who do you consider to be your support system?

Religious/Spiritual Beliefs:

Additional Information:

Are you currently employed? _____

If yes, occupation: _____

Do you enjoy your work? Is there anything stressful about your work?

What significant life changes or stressful events have you experienced recently?

What is motivating you to seek treatment at this time?

What would you like to accomplish out of your time in therapy?

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