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# 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:

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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

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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?

_____
_____