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INDIVIDUAL INFORMATION - INTAKE FORM

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ MALE/FEMALE: _____

NAME PREFERRED TO BE CALLED: _____

DATE OF BIRTH and PLACE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONES: Home: _____ Cell: _____

Work: _____ Email: _____

CONFIDENTIAL/PRIVATE MESSAGES CAN BE LEFT AT: Phone: _____

PERSON & PHONE NO. TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

_____

_____

_____

_____

Estimate the severity of above problem: Mild _____ Moderate _____ Severe _____ Very severe ____

CURRENT: Marital status: _____ Live with someone: _____ Name: _____ Years: _____

PAST & PRESENT MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

_____

_____

_____

_____

PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

1. _____

2. _____

3. _____

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father: _____

_____

_____

Mother: _____

_____

_____

Stepparents: _____

_____

_____

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1. _____

2. _____

3. _____

MEDICAL DOCTOR (S) (name/phone):

_____

_____

_____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

_____

_____

_____

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.):

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, deaths, major life stressors, any school/behavioral/problems, abusive/alcoholic parent):

IF PARENTS DIVORCED: Your age at the time: _____.
DESCRIBE HOW IT AFFECTED YOU AT THE TIME

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

OCCUPATION (former, if retired): _____

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, browsing, etc.):

Facebook: _____ YouTube: _____ Gaming: _____ Browsing: _____ Other: _____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

Please circle the symptoms that you are currently experiencing (if any):

SYMPTOMS:	NONE	MILD	MODERATE	SEVERE	FOR HOW LONG
Sadness/Depression	0	1	2	3	
Hopelessness	0	1	2	3	
Suicidal Thoughts	0	1	2	3	
Sleep Problems	0	1	2	3	
Change in Appetite	0	1	2	3	
Weight Change	0	1	2	3	
Inability to Concentrate	0	1	2	3	
Obsessive Thoughts	0	1	2	3	
Tension/Anxiety	0	1	2	3	
Panic Attacks	0	1	2	3	
Memory Problems	0	1	2	3	
Compulsive Behaviors	0	1	2	3	
Hostility/Anger	0	1	2	3	
Acts of Violence	0	1	2	3	
Social Isolation	0	1	2	3	
Strange Thoughts	0	1	2	3	
Sexual Problems	0	1	2	3	
Phobias	0	1	2	3	
Other					

PLEASE ADD ANY ADDITIONAL INFORMATION THAT YOU WOULD LIKE ME TO KNOW: