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INTAKE FORM # ___________

Name: ____ *Date:* ______________

Address: ____________________________ *City*________________ *Zip Code* ______

*Telephone: Home:*_____________ *Work:*______________ *Mobile:*__________________

Male: ___ *Female:* ___ *D.O.B.:* _________ *Age:* ______

Highest grade/degree: _____________________ *Referred by:* ______________________

Occupation/position: _____________________ *Place of Employment* ________________

Marital Status: ____ *Years of marriage:* ____ *Dates of Previous Marriage* __________

Spouse name: ________________ *Age:* ________ *Occupation:* ___________________

*Spouse's Employment:*____

Children (names/ages): ____

*Parents/step-parents (names/ages/year of death):*____________________________

*Your siblings(names/ages):*____

Person to call in emergency: ____________________*Telephone:*________________

Medical doctor: ___________________________ *Telephone:*______________________

Current medications (include dosage and prescribing physician):

____

*Reasons for seeking treatment:*____

____

#____________

PERSONAL SYMPTOM HISTORY

Check All That Apply To You

___Headaches	___ Depression	___Marital Problems	___Shy/Withdrawn
___Dizziness	___ Anxiety	___Financial Problems	___Fear of Leaving Home
___Fainting Spells	___ Unable to relax	___Work Problems	___Compulsive Behavior
___Heart Palpitations	___ Constant Worrying	___School Problems	___Hyperactivity
___Stomach Problem	___ Panic Attacks	___Recent Loss	___Legal Problems
___Seizures	___ Feel Tense	___Sexual Problems	___Disoriented
___Fatigue	___ Can't Make Decisions	___Sexual Preoccupations	___Memory Problems
___Diarrhea	___ Mood Swings	___Battered/Abused as Child	___Dislike Weekend/Holiday
___Weight Problems	___ Irritable	___Sexually Abused as Child	___ Flashbacks
___No Appetite	___ Inferiority Feelings	___Physically Abused now	___Nightmares
___Sleep Problems	___Overambitious	___Emotionally Abused now	___Hallucinations
___Drug Use	___Suicidal Ideations	___Violent Behavior	___Other (Identify)
___Excessive Alcohol Use	___Past Suicide Attempts	___Bad Home Conditions	

Past and present medical care: (Specify major problems, chronic illness, allergies, accidents, hospitalizations):

____

____

*Past psychiatric hospitalizations:*_____________________________

Past psychotherapy:

1. *Psychotherapist:* ______________________ *Dates:* _______ *to* ____________

   Initial reason: ____

   Outcome: ____

2. *Psychotherapist:* _____________________ *Dates:* __________ *to* ___________

   Initial reason: ____

   Outcome: ____

   Medications used to treat emotional problems (names/dates/prescribing physician):

   ____

____

Past and present cigarette/drug/alcohol use/abuse (any addiction, AA/NA etc.):

____

Traumatic events, approximate dates:

____

____

Present living situation:

____

____

____

Signature