Therapy with Cynthia – Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form prior to your first session.

Name:

____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____

(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Please list any children/age:

____

Address:

____

(Street, City, State, Zip code)

____

Home Phone: ( ) Cell/Other Phone: ( )

May we leave a message? □ Yes □ No May we leave a message? □ Yes □ No

E-mail: ____

May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):
____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

____

____

Are you currently taking any prescription medication?
□ Yes □ No

Please list:
____

____

Have you ever been prescribed psychiatric medication?
□ Yes □ No
Please list and provide dates:
____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
____

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: ____

3. How many times per week do you generally exercise? ____________________

What types of exercise do you participate in?

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No □ Yes

If yes, for approximately how long?

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No □ Yes

If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain?
□ No □ Yes

If yes, please describe:

8. Do you drink alcohol more than once a week?

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly

10. Are you currently in a romantic relationship?
□ No
□ Yes □ Infrequently
□ Yes
□ Never

If yes, for how long? ___________________________________

On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently:
____

____

____

____

____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.). Yes/No

If yes please circle:

Alcohol/Substance Abuse, Anxiety, Bipolar Disorder, Depression, Domestic Violence, Eating Disorders, Obesity , Obsessive Compulsive Behavior , Schizophrenia, Suicide Attempts

Please List Family Member (s)
____

ADDITIONAL INFORMATION: 1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

____

____

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

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

____

____

3. What do you consider to be some of your strengths?

____

____

____

4. What do you consider to be some of your weaknesses?

____

____

____

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

____

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