Initial Intake: Confidential Information

Date:

Name: **Date of Birth:**

Full Current Address (with Zip):

Relationship Status:

Phone: **Ok to leave messages on phone? Y / N**

Email Address: **Ok to contact via email? Y / N**

Emergency Contact Person / Their Relationship to You / Their Contact Information:

Credit Card Information (kept on file, not used):

Number: **Exp:** **3-digit Security Code:**

Referred From:

Please briefly describe your reason and goals in coming to therapy today:

Have you ever been in psychotherapy before?

If so, when, why, and for how long?

What was your experience in therapy like?

Are you currently taking psychiatric medications? Y / N Have you in the past? Y / N

If so, which medication(s) and at what dose(s)?

Please briefly describe the reason you are / were taking this medication:

Are you currently taking any non-psychiatric medication? Y / N

If so, what are you taking and please briefly describe why:

Are you currently having any thoughts of hurting yourself? Y / N

If you responded yes, what sort of thoughts are you having?

____Thoughts, but no plan for self-harm
____Thoughts, and I have thought about specific ways I might harm myself
____Thoughts, and I have a plan about how I will harm myself

Have you had thoughts about harming yourself in the past?

Have you ever engaged in any of the following behaviors?

____Excessive alcohol or substance use/abuse
____Binge eating and / or purging
____Cutting

Have you ever been hospitalized due to mental health concerns? Y / N

Have you been involved in legal troubles? Have you ever been involved in a lawsuit?

If you answered yes to either question, please describe briefly:

Please briefly describe your work history and / or current employment:

Please briefly describe your support system (relatives, co-workers, family, and friends you feel close to and could talk to about your personal concerns):

Is there anything else you'd like to mention that hasn't been asked?

Please check the areas that are of current concern for you and then circle the one or more that are the primary concern:

____Anxiety ____Depression ____Anger Management ____Eating/Food Concerns ____Family issues ____Financial Stressors ____Identity ____Shame ____Loss ____Perfectionism ____Procrastination or Feeling Stuck ____Manic Symptoms or Behavior ____Sleep Issues ____Sexual concerns ____Obsessive/Compulsive Struggles ____Guilt ____Physical Problems/Chronic Pain ____Past abuse/trauma ____Current abuse/trauma ____Suicidal Thoughts ____Thoughts of hurting others ____Relationship Concerns ____Self-Confidence ____Substance Use/Abuse ____Work Issues

How much do these concerns impact your functioning (work, health, personal relationships)

_____None _____Mild _____Moderate _____Severe

Privacy Notification: The principal purpose for requesting the information above on this form s to aid the therapist who will be working with you. Furnishing this information is voluntary. The Notice of Privacy Practices describes how mental health information may be used and disclosed.

Confidentiality: All information contained on this form and information collected within the process of psychotherapy is confidential and will not be disclosed except upon your written authorization or in accordance with legal requirements as in the case of threats or actual harm to self or others or suspected elder or child abuse. Please sign below indicating you've read the above statement:

Signature: **Date:**