Intake Form

Name _____ Age____ Date of birth _____

Address _____

Phone _____ Ok to text? ☐ Yes ☐ No Voicemail? ☐ Yes ☐ No

Email_____

Is it okay to contact you via email, strictly for the purposes of scheduling? ☐ Yes ☐ No

Emergency contact name_____ Phone_____

Employment/income source_____

Briefly describe the concerns that have brought you here.

_____

_____

_____

_____

Please circle any current or past issues that still affect you.

Feeling Tense	Gambling	Worry/Anxiety	Alcohol/ Drug Use
Stress	Pornography	Panic Attacks	Sexual Identity Issues
Feeling Inferior	Family Issues	Hopelessness	Relationship Issues
Distractibility	Pregnancy Issues	Irritability	Academic Issues
Anger	Victim of Crime	Self-Harm	Suicidal Thoughts
Domestic violence	Phobias	Obsessions	Sexual Assault/Rape
Lying/Deceitfulness	Sleep Issues	Eating Concerns	Criminal History
Death of a Loved One	Hallucinations	Childhood Abuse	Flashbacks

Have you previously seen a therapist? _____ When? _____

With whom? _____ For what issue/s? _____

Please list current psychotropic medications _____

_____

Have you had any previous attempts at self-harm or suicide or thoughts of suicide?

_____

_____

Who lives with you? (name, relationship, age)_____

_____

_____