# I N T A K E  F O R M

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 and bring it 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: _____

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

□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) 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 to 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? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

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.).

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |
| Obsessive Compulsive Behavior | yes/no | |
| Schizophrenia | yes/no | |
| Suicide Attempts | yes/no | |

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 weakness?

_____

_____

_____

_____

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

_____

_____

_____

# Cancellation Policy

We/I, _____ understand and agree to the following:

1. To cancel an appointment it is necessary that I/we call 347-687-0816 and cancel the appointment, 24 hours prior to the scheduled appointment time. We/I understand a full session fee will be charged to the account in the case of not cancelling a scheduled within the 24 hour period before the appointment. (Email cancellations are not considered appropriate means of cancellation).

2. I understand that therapy/life coaching/counseling requires consistency and regularity. If we/I miss 3 appointments, we/I understand our/my case will be closed.

Client signature_____

Therapist signature _____

Date_____

Credit/Debit Card

□ Visa □MasterCard □Discover □Amex

Card number _____

Expiration date_____

CVV code_____

Zip code _____

I agree for my card to be charged a full session fee for not cancelling within 24 hours.

Signature _____ Date_____

# Confidentiality Agreement

I understand that my treatment is confidential and no information will be released to anyone regarding my sessions without my written or verbal consent.

I also understand that in an instance of my expressing intent to harm myself or another person, this confidentiality agreement is void.

Client_____

Therapist_____

Date_____

# Therapist Pledge

My goal as your therapist is to assist you in getting to the place in your life where you experience emotional balance and stability. I am charged to support, encourage and guide you to the path of emotional wholeness.

There are times when I will tell you things that you don't want to hear but I will always tell you in a caring, supportive and respectful manner. I will provide a safe environment for you to explore whatever stands in the way of optimum functioning in your life.

It is always your decision to take the counsel that is offered or reject it. Ultimately, your success in therapy is wholly dependent on your willingness to do the hard work of facing issues that prevent you from having the life you desire. My role is to guide and support you to the desired path of emotional wellness.

From time to time, I may assign homework assignments to be completed by you or your spouse/partner and you. These assignments are an extension of your treatment and will be used to enhance individual/couple sessions.

Client Signature_____

Couple Signature_____

Therapist Signature_____

Date _____