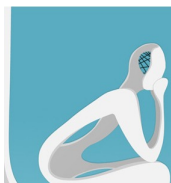


INTAKE FORM

Welcome to my office! So I can get to know you better, please take a few minutes to fill out the questions below and bring it to your first session. Note: All information is held in confidence and will not be shared unless your safety is at risk.

Your Name				Today's Date			
DOB	Age	<input type="radio"/> Male	<input type="radio"/> Female				
Street Address				Email address			
City				State		Zip	
Home Phone				OK to leave message?		<input type="radio"/> Yes	<input type="radio"/> No
Work Phone				OK to leave message?		<input type="radio"/> Yes	<input type="radio"/> No
Mobile Phone				OK to leave message?		<input type="radio"/> Yes	<input type="radio"/> No
Marital Status		<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Separated	<input type="radio"/> Divorced	<input type="radio"/> Widowed	<input type="radio"/> Living Together
Prior Therapists Name				Prior Therapists Number			
Spouse/Partner's Name							
DOB	Age	<input type="radio"/> Male	<input type="radio"/> Female				
Street Address							
City				State		Zip	
Best Number to Contact Spouse/Partner							
Child's Name				Child's Age/Gender			
Child's Name				Child's Age/Gender			
Child's Name				Child's Age/Gender			

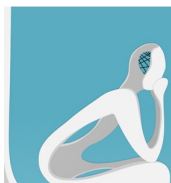


Employer/School	Occupation (Years at Job)
Employer Address	City, State ZIP

Emergency Contact	Phone Number	
Relationship to You		
Insurance Information		
Primary Insurance	Policy #	Phone #
Subscriber's Name	Subscriber's ID#	
Secondary Insurance	Policy #	Phone #
Subscriber's Name	Subscriber's ID#	
Subscriber's Employer		

Primary Care Physician	
Name	Date Last Seen
Phone Number	Fax Number
Address	City, State ZIP

Medical History
Current Medications
Presenting Concerns
Please describe your primary reason for seeking treatment at this time
Was there an event which caused these problems <input type="radio"/> Yes <input type="radio"/> No
If Yes, Please Describe



Pre-Treatment Survey - Rate how much you were affected by the following in the past week:					
	N/A	Mildly	Moderate	Severe	Constant
Concerns about your body or physical health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts or behaviors you do over and over again	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unusually high energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling sad, blue, or depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety, "nerves", or tension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anger, hostility, or irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fears of things or places	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beliefs that others want to hurt you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drinking too much or using drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unreal, strange, or "uncommon" thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Rate how well you are doing						
	N/A	No Problems	Mild Problems	Moderate Problems	Serious Problems	Cannot Function
On your job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Primary relationship (marriage, partner)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Friends, non-family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flashbacks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Who referred you? _____

What are your spiritual/religious beliefs? _____

What are your personal strengths? _____

What are your goals for therapy? _____

Thank you for taking the time to fill out this form. It helps me help you!