PATIENT INTAKE FORM

Your name:_____

Address: _____

_____

Email address: _____

Date of Birth_____

Telephone Number:_____ **Email address:**_____

Person to contact in an emergency:_____ **(Relationship)** _____
Phone number:_____

Religion _____ **Ethnicity** _____ **Education** _____

Occupation (if not retired) _____

Name and age of your parents: _____

Name & ages of brothers & sisters_____

Names & ages of children:_____
_____

Describe your childhood to the best of your ability (use back of page if necessary:_____

_____

_____

_____

_____

Please list any illnesses – physical or psychological including treatment for mental health and/or addictions with dates of treatment:

Please state in your own words, the reason for your visit:

Goals for Therapy:

Previous Counseling History:

Successes and/or dissatisfaction(s) with previous therapy and why:

_____

_____

_____

Please circle any of the following that apply to you:

Depression	**Worrying Excessively**	**Hearing voices**
Feeling hopeless	**Feeling worthless**	**Seeing things**
Too anxious to rest	**People are against you**	**Tension**
Poor energy	**Not interest in doing anything**	**Panic attacks**
No appetite	**Nightmares about the past**	**Drinking too much**
Too many drugs	**Fatigue**	**Can't focus**
Sleep problems	**Repetitive thoughts**	**Over-eating**
Excessive energy	**Unexplained euphoria**	**Compulsive**
Phobias/fears	**Memory problems**	**Can't concentrate**
Tics or jerks	**Easily get lost**	**Forgetfulness**
Sleep too much	**No energy to for self-care**	**Talk too fast**
Impulsive spending	**Can't get house clean**	**Racing thoughts**
Hyperactive	**Lethargic**	**Loss of time**

Please list all medication you are currently taking:

_____

_____

Who referred you? _____

Please read carefully and initial the following:

_____ Payment is due at time of visit. Sessions are a full hour.

_____ Insurance is not accepted, but paperwork for reimbursement will be completed for you.

_____ This time is reserved for you, therefor 48 hours cancellation is requested, you will be offered a makeup and payment is due.

____ If you are not physically capable of keeping a scheduled, (or make-up) appointment, a phone or Skype session will be offered to you.

_____ Therapy will not work without mutual trust. We are both expected to keep our appointments.

_____ No emails or text messages to cancel appointments - by phone only.

____ When it is time to stop therapy, you agree to a final session for closure.

Extra writing space: