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Confidential Intake Form

Date of Intake: __/__/____

Please fill out this information form as thoroughly as possible. The information you provide will be confidentiality used to obtain a broader understanding of your therapeutic and mental health needs.

Identifying Information

Name: _____ DOB: ___/___/___ Age: _____

Gender: _____ Relationship Status: _____ Race: _____

Educational History

Highest grade completed: High School GED Some College Bachelors Masters Professional Other

If you are currently a student, what is your area of study and name of school?
_____

History of difficulties reading/writing, or other learning disabilities: ____ Yes ____ No
Explain: _____

Employment History

Employment Status: Part-Time Fulltime Seasonal Unemployed Retired Receive Disability Other

Place/type of Employment: _____
Length of Employment: _____

Do you enjoy the work? Yes / No
Is anything affecting your work performance? ____Yes ____ No
If yes, please explain: _____
_____

Military History

Military experience: Yes / No Branch/Rank: _____

Time served: _____ Type of discharge: _____

Were you ever deployed during your service? ____Yes ____No

Are you experiencing any behavioral health concerns related to your service? _____

Any other Military history? _____

Family History

Relationship Status: Single Engaged Married Separated Divorced Widow(er) Committed Partnership
How long: _____

Name of Spouse/Partner: _____
Does your significant other use alcohol or drugs? Yes / No
Does significant other have any mental health issues? Yes / No
Please describe: _____

Who lives with you? _____

Who were your primary caregivers? _____

Is your mother and father living or deceased? _____
If deceased, date/age/cause of death?
Mother: _____
Father: _____
Siblings: Number of Brothers: _____ Number of Sisters: _____ Only Child: _____ Yes _____ No

Children (Please list names and ages): _____
_____

Describe your relationship with family members: _____
_____

Any history of miscarriages, stillbirths, terminated pregnancies? ____Yes ____No
Please explain: _____

Family History of Substance Abuse: Yes / No Whom/Substances: _____
Family History of Mental Illness (please include Domestic Violence): ____Yes ____No
Whom/Illness: _____
If yes to family history of either substance abuse or mental illness, how long:
_____

Health History
Name, Address/Phone of current Primary Care Physician (PCP): _____
_____

List any health issues/illness/disabilities: _____
_____

List any hospitalizations/accidents: _____

Have you experienced a head injury? _____ Yes _____ No
If so, please explain _____

List any specific sleep problems you are experiencing: _____
How many times per week do you generally exercise? _____
List any problems with your appetite or eating patterns: _____

Please circle any areas in which you have concerns or that you feel apply to you:

Anxiety	Feeling worthless	Sexual problems	Self-harm behaviors
Anger	Difficulty falling asleep	Difficulty concentrating	Work stress
Alcohol/substance Use	Difficulty staying asleep	Mood swings	Impulsive behavior
Grief/loss	Sleeping more than usual	Loneliness	Feeling suicidal
Depression	Significant weight gain/loss	Social isolation	Feeling guilty
Panic attacks	Low Self-esteem	Childhood abuse	Tiredness/fatigue
Difficulty making decisions	Poor motivation	Problems with memory	Nightmares
Irritability	Body image concerns	Phobias/fears	Body aches/pains
Feeling hopeless	Relationship difficulties	Obsessions/compulsions	Hearing voices
Hallucinations	Elevated mood	Feeling I am being watched	Binge eating or purging
Cannot make decisions	Empty feelings	Financial stress	Regrets
Headaches	Identity Issues	Loss of faith	Worry
Trauma history	Controlling	Loss of meaning in life	Internet addiction
Eating problems	Disturbing thoughts	Distractible	Confused

Current Medications

Medication Name	Dosage	Frequency	Start Date	Prescribing Physician

Mental Health History

Past/Current Mental Health Treatment ☐ None Identified

Date	With Whom	Length of therapy	Medications prescribed	Diagnosis

Have you ever been admitted to a psychiatric hospital for mental health or substance abuse?__Yes __No
If yes, where/when?
_____

Reason for seeking therapy (Please describe your reasons for seeking help and how you think therapy could be beneficial).
_____
_____
_____
_____
_____

How long have you been aware of this problem? _____

Substance Abuse History

Previous Chemical Dependency Treatment ☐ None Identified

Date	Facility	Length of treatment	Follow-up

Substance Use History ☐ None Identified

Substance Used	Age of 1st use	Age of Regular use	Amt/Frequency of current use	Method of use	Last use
Alcohol					
Marijuana					
Cocaine					
Opiates					
Benzodiazepines					
Barbiturates					
Hallucinogens					
Amphetamines					
Nicotine/Caffeine					

Is there problematic chemical or alcohol use in the home environment? Yes / No Whom: _____
Do you attend 12-step meetings (AA/CA/NA)? Yes / No If yes, how often: _____
Do you have a sponsor? Yes / No
Do you believe that abstinence is necessary for recovery? Yes / No

Have you ever been prescribed Antabuse, Revia, Methadone, or Buprenorphine? Yes / No
When: _____
What is the longest period of abstinence from all substances including alcohol? _____

Safety
Have you ever intentionally hurt yourself (e.g. cutting, burning)? : Yes / No
If yes, when was most recent episode? _____

Have you ever attempted suicide or had a plan to physically harm yourself? Yes / No
If yes, when was most recent episode? _____

Are you currently having suicidal thoughts or thoughts to physically harm yourself? Yes / No
Do you currently have a plan to commit suicide? Yes / No

Are you a survivor of emotional, physical, sexual abuse, neglect, trauma, war, terrorism?
Please explain: _____

Legal History
Do you have a history of or are you currently experiencing any legal problems? Yes / No
Please explain:

Date of charge	Type of charge	Outcome	Pending/Resolved

Spiritual History
Do you consider yourself a religious and/or spiritual person? ____ Yes ____ No

Are you currently involved in a Faith Community: Yes / No Where: _____

What are some of your core beliefs/values? _____
_____
_____

Have you experienced spiritual/religious events that have caused concerns or that you feel remain unresolved?
____Yes ____ No Please explain:
_____
_____

What are your strengths? _____
_____

What areas would you like to experience growth? _____
_____