INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

Birth Date:_____/_____/_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

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

Work Phone: ( ) - May we leave a msg? □Yes □No

Cell/Other Phone: ( ) - May we leave a msg? □Yes □No

May we leave a text? □Yes □No

Emergency Contact: ( ) - May we leave a msg? □Yes □No

E-mail:_____May we email you? □Yes □No
Cell Phone:_____May we text you? □Yes □No
*Please be aware that email and texts might not be confidential.

How did you hear about us? _____

Are you currently receiving psychotherapy elsewhere? □Yes □No

Have you had previous psychotherapy?
□No
□Yes, at Previous therapist's name_____
When? _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes
□No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?
□Yes □No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any hospitalizations, major illnesses, surgeries or health concerns:

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

4. Do you regularly use alcohol? □ No □ Yes

How often?

_____

5. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

6. Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?
□ Frequently □ Sometimes □ Rarely □ Never

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

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

8. In the last year, have you experienced any significant life changes or stressors:

9. Self care; please list any medical check ups, massage, alternative health, etc.

Have you ever experienced:
Extreme depressed mood yes/no
Wild Mood Swings yes/no
Panic Attacks yes/no
Phobias yes/no
Sleep Disturbances yes/no
Hallucinations yes/no
Unexplained memory lapses yes/no
Alcohol/Substance Abuse yes/no
Frequent Body Complaints yes/no
Eating Disorder yes/no
Body Image Issues yes/no

Repetitive Thoughts or Behaviors (e.g., Obsessions) yes/no
Homicidal Thoughts yes/no
Suicide Attempt yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position? _____

How long? _____

If yes, are you happy at your current position? _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty Family Member
Depression yes/no
Anxiety Disorders yes/no
Panic Attacks yes/no
Schizophrenia yes/no
Alcohol/Substance Abuse yes/no
Eating Disorders yes/no
Learning Disabilities yes/no
Trauma History yes/no
Suicide Attempts yes/no

WE HAVE A 24 HOUR CANCELLATION POLICY. CLIENT WILL BE RESPONSIBLE FOR FULL FEE FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE.

_____ _____
Client Signature Client parent or guardian if under 18

_____
Today's date

LIMITS OF CONFIDENTIALITY

Confidentiality between client and therapist is of the utmost importance. Your verbal communication and clinical records are strictly confidential except for the following:

1. Information you and /or your child or children report about physical of sexual abuse of a minor or an elder person; in such cases I am obligated by Connecticut State Law to report this information to the CT Department of Children and Families.
2. If you provide information that informs me that you are in danger of harming yourself of others.
3. Where you sign a release to have specific information shared.
4. Information shared with your insurance company to process your claims.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date