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.

DEMOGRAPHICS

Name: ______________________________ __________________ __________________
Last First Middle Initial

Address 1: ____
Street Address

Address 2: ____
Suite or Apt #

Address 3: ____
City State Zip

Birth Date: ____ / ____ / ________ Age: ________

Gender: ☐ Male ☐ Female ☐ Other

Home Phone:	May we leave a message?	☐ Yes	☐ No
Work Phone:	May we leave a message?	☐ Yes	☐ No
Cell Phone:	May we leave a message?	☐ Yes	☐ No
Cell Phone:	May we send a text?*	☐ Yes	☐ No
Email:	May we email you?*	☐ Yes	☐ No

RELATIONSHIP STATUS

☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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

If yes, on a scale of 1-10, how would you rate the quality of your current relationship? ______

If no, how long has it been since your last significant relationship? ______

Children: ☐ Yes ☐ No If Yes, how many? ________

OCCUPATIONAL STATUS

Are you currently employed? ☐ Yes ☐ No

If yes, who is your current employer? ________________________________

If yes, what is your current position? ________________________________

If yes, how long have you been with this employer? ______

Are you happy with your current position? ☐ Yes ☐ No

EMERGENCY CONTACT

Name: ________________________ ____________ ____________

Last First Middle Initial

____

Relationship

Home Phone: ____________	May we leave a message?	☐ Yes	☐ No
Work Phone: ____________	May we leave a message?	☐ Yes	☐ No
Cell Phone: ____________	May we leave a message?	☐ Yes	☐ No
Cell Phone: ____________	May we send a text?*	☐ Yes	☐ No
Email: ________________	May we email you?*	☐ Yes	☐ No

PARENT/GUARDIAN (if applicable)

Name: ________________________ ____________ ____________

Last First Middle Initial

____

Relationship

Home Phone:	May we leave a message?	☐ Yes	☐ No
Work Phone:	May we leave a message?	☐ Yes	☐ No
Cell Phone:	May we leave a message?	☐ Yes	☐ No
Cell Phone:	May we send a text?*	☐ Yes	☐ No
Email:	May we email you?*	☐ Yes	☐ No

**Please be aware that texts and email may not be confidential.*

MENTAL HEALTH STATUS

Are you currently receiving psychotherapy elsewhere?	☐ Yes	☐ No
Have you had psychotherapy previously?	☐ Yes	☐ No
If yes, please provide previous therapist's name: ______________________________		
If yes, when?: ____		

Are you currently taking prescribed psychiatric medication?	☐ Yes	☐ No
If yes, please list:	1. ______________________________	
	2. ______________________________	
	3. ______________________________	
	4. ______________________________	
	5. ______________________________	

Have you ever been prescribed psychiatric medication in the past?	☐ Yes	☐ No
If yes, please list:	1. ______________________________	
	2. ______________________________	
	3. ______________________________	
	4. ______________________________	
	5. ______________________________	

Have you ever been hospitalized for psychiatric reasons?	☐ Yes	☐ No
If yes, please explain: ______________________________________		

Do you currently have suicidal thoughts?			
☐ Frequently	☐ Sometimes	☐ Rarely	☐ Never

Have you ever had suicidal thoughts in the past?			
☐ Frequently	☐ Sometimes	☐ Rarely	☐ Never

In the last year, have you experienced any significant life changes?	☐ Yes	☐ No
If yes, please list:	______	
	______	
	______	
	______	
	______	

Have you ever experienced any of the following?		
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 or substance abuse	☐ Yes	☐ No
Frequent bodily complaints	☐ Yes	☐ No
Eating Disorder(s)	☐ Yes	☐ No
Body Image Issues	☐ Yes	☐ No
Obsessive Thoughts or Behaviors	☐ Yes	☐ No
Homicidal Thoughts	☐ Yes	☐ No
Suicide Attempt	☐ Yes	☐ No

PERSONAL HEALTH HISTORY

How is your physical health at present?				
☐ Poor	☐ Unsatisfactory	☐ Satisfactory	☐ Good	☐ Very Good

Have you ever been hospitalized for medical reasons?	☐ Yes	☐ No
If yes, please explain: ______		

Please list any major illnesses, surgeries or current health concerns:
1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Are you currently having any trouble sleeping?	☐ Yes	☐ No
If yes, check as applicable:	☐ Sleeping too little	
	☐ Sleeping too much	
	☐ Sleeping too little	
	☐ Poor quality sleep	

Do you regularly use alcohol?	☐ Yes	☐ No
If yes, how often?	☐ Daily	
	☐ A few times a week	
	☐ A few times a month	
	☐ On rare occasions	

Do you engage in recreational drug use?	☐ Yes	☐ No
If yes, how often?	☐ Daily	
	☐ A few times a week	
	☐ A few times a month	
	☐ On rare occasions	

Please list any regular self-care (well-checks, massage, health alternatives, etc.:
1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

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(s)
Depression	☐ Yes	☐ No	
Anxiety	☐ Yes	☐ No	
Panic Attacks	☐ Yes	☐ No	
Schizophrenia	☐ Yes	☐ No	
Alcohol Abuse	☐ Yes	☐ No	
Substance Abuse	☐ Yes	☐ No	
Eating Disorders	☐ Yes	☐ No	
Learning Disabilities	☐ Yes	☐ No	
Trauma History	☐ Yes	☐ No	
Suicide Attempts	☐ Yes	☐ No	

INSURANCE

For your protection and confidentiality we recommend that, if possible, you pay for your counseling without using insurance. Insurance companies require us to disclose highly personal information about you. The confidentiality and privacy of this information cannot be guaranteed. They also often restrict the number of sessions they will authorize, even if we agree that you still need help.

If you choose to use your insurance, most insurance plans that provide out-of-network benefits will provide coverage for our services. We can provide you with a monthly invoice to submit to your insurance company for reimbursement.

CANCELLATION POLICY

Appointments cancelled less than 24 hours before the scheduled appointment time, or missed altogether, are subject to a cancellation fee equal to the amount of a full fee appointment. The amount due will be charged to the credit card on file.

Please provide credit card information for our files:

__________ - __________ - __________ - __________ ____ / ____ / ____ _____

Card Number Expiration Date CRV Code

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