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Initial Intake Data (rev 2015)

Name: ____ Date: ______________________________
Emergency Contact: ______________________________ Your Age:____________________________
Name/Ages of Children____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Lvng Tgthr ____ Other_____

Spouse/Partner's Name: ___________________Best Phone Number for reaching you:___________________

Briefly describe your reason for seeking psychotherapy?_____________________________________
____
____
____
____
____

How long has this been a problem for you? ____
____
____
____

Have you been in psychotherapy before and was it for the reason that you are here today? ______________
____
____
____

Was it helpful? ____

What other ways have you tried to handle this problem? ____________________________________
____
____

	Not Very Serious				Very Serious
Overall, how serious is this problem for you?	1	2	3	4	5

How has this problem affected your:

	Does not Apply	Not at all				Very much
Marriage/Partner?	( )	1	2	3	4	5
Family?	( )	1	2	3	4	5
Job/School?	( )	1	2	3	4	5
Friendships?	( )	1	2	3	4	5
Financial Situation?	( )	1	2	3	4	5
Legal Situation?	( )	1	2	3	4	5
Health?	( )	1	2	3	4	5
Anxiety/Nerves?	( )	1	2	3	4	5
Mood?	( )	1	2	3	4	5
Eating Habits?	( )	1	2	3	4	5
Sleeping Habits?	( )	1	2	3	4	5
Ability to Concentrate?	( )	1	2	3	4	5
Child Rearing?	( )	1	2	3	4	5
Ability to control Temper?	( )	1	2	3	4	5
Spirituality?	( )	1	2	3	4	5
Other? _______________	( )	1	2	3	4	5

____

Please check the appropriate response:

**Have you ever felt like you should cut down on your alcohol or other drug use (including prescription drugs?
___ Yes ___No**
Have you ever felt guilty about your drinking or drug use? ___ Yes ___ No

Have you ever had to take a drink or use a drug the next day to steady your nerves?___ Yes ___ No

Are you a recovering alcoholic or recovering drug addict?___ Yes ___ No

Is there a family history of problems with alcohol or drug use in your family?___ Yes ___ No

Do you now smoke cigarettes or cigars? ___yes _____no If yes, how many/day?_________

Do you use any other tobacco products? ___Pipe ___Snuff___Chewing Tobacco____Cigars_____Other?

If yes, how many times a day? ________________times/day

Please fill out the following:

Over the counter Drugs (Specify):	Dosage/mg (times/day/week/year	Method of Administration (oral/patch/IV)
___________________________	__________________________	__________________________
_________________________	__________________________	__________________________
___________________________	__________________________	__________________________
___________________________	_______________________	_________________________
___________________________	_______________________	_________________________

Prescription Drugs (Specify):

___________________________	__________________________	__________________________
_________________________	__________________________	___________________________
___________________________	__________________________	_________________________
___________________________	_______________________	_________________________
___________________________	__________________________	___________________________
_________________________	__________________________	___________________________
___________________________	____________________________	____________________________

Alcohol	_______________	________	____________________________
Marijuana;Spice/K2,etc	_______________	________	_________________________
Cocaine	_______________	________	__________________________
Heroin	__________________________		____________________________
Amphetamines/Stimulants	_______________	________	____________________________
Barbiturates	_______________	________	____________________________
Benzodiazepines	_______________	________	____________________________
LSD;ecstacy;etc	______________	_______	____________________________
Opiates (vicodan,oxycodone,etc)	_______________	________	____________________________
Other (Specify)	________________	________	____________________________
	_______________	________	_____ _____ _____ _____
Herbs, vitamins/minerals Supplements	_______________	_________	______ _____ ______ ______
	___________________________		______________________________
	___________________________		______________________________
	____________________________		_______________________________

Describe any medical problems?____
____
____
____
____

When was your last physical and with whom?____________________________________

Other Physicians involved in your care?____
____

What do you hope to accomplish in psychotherapy?_________________________________
____
____
____