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Psychotherapy Intake Form

Date _____

Name _____ Preferred Name _____

Age _____ Date of Birth _____

Birth Sex _____ Gender Identity _____

Street Address _____

City _____ State _____ Zip Code _____ County _____

Home Phone _____ Work Phone _____

Cell Phone _____ Is it okay to leave a discreet voicemail? _____

Email Address _____

Marital Status_____ If married, number of years ____

Emergency Contact _____ Relationship _____

Emergency Phone Number _____

Highest Level of Education Attained _____

Are you currently employed? _____ Name of Employer _____

Job Title _____ How long? _____

Employment Satisfaction: (poor) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

How did you hear about DSW Diversity Consulting?

_____

_____

Please briefly describe your presenting concern:

_____
_____
_____
_____
_____
_____

How long have you had these concerns? _____

What do you hope to gain from therapy?

_____
_____
_____
_____
_____
_____

How long do you expect to be in therapy to accomplish these goals? _____

Medical Information

Please explain any significant medical problems, symptoms, or illnesses

_____
_____
_____
_____

How many hours of sleep do you get per night on average? _____

Do you have difficulty falling asleep? _____ If so, how often? _____

Do you frequently awaken in the middle of the night? _____ If so, how often? _____

Do you have frequent nightmares? _____ If so, how often? _____

Current Medications

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? _____ If so, how many per day? _____

Do you consume caffeine? _____ If so, how often? _____

Do you drink alcohol? ____ If so, how often? _____ How much? _____

Do you smoke marijuana? _____ If so, how often? _____ How much? _____

Do you use any illicit drugs? _____ If so, which drug? _____

Have you ever abused any prescription drugs? _____ If so, which? _____

Have there ever been any negative consequences due to substance use (i.e. DUIs, arrests, fights, conflicts with family members or friends)? If so, please describe:

_____

_____

_____

_____

Have you ever gone to therapy before? _____ Length of therapy? _____

Reason for therapy? _____

What did you find helpful about the therapy?

_____

_____

_____

Have you ever been admitted to an inpatient psychiatric hospital? _____

If so, what was the approximate date and reason?

_____

_____

Have you ever attempted suicide? _____ If so, when? _____

What method was used (i.e. overdose, hanging, etc.)

_____

_____

Family and Relationship Information

Marital Status _____

Were you previously married? _____ How many times? _____

Sexual Orientation_____

Are you currently in a relationship? _____ Length of Current Relationship _____

Relationship Satisfaction (extremely dissatisfied) 1 2 3 4 5 6 7 (extremely satisfied)

Do you have children? _____ How many? _____ Ages? _____

Where there any miscarriages? _____ Abortions? _____

Is there a family history of mental health issues or substance use? _____

Please explain:

_____

_____

_____

_____

Are there any current stressors in your life (i.e. job loss, financial problems, relationship stress, etc.)?

_____

_____

_____

Do you have a history of physical, emotional, or sexual abuse? _____ If so, please briefly explain:

_____

_____

_____

_____

What do you believe are your strengths?

_____

_____

_____

_____

Symptom Checklist

☐ Anxious	☐ Severe weight loss	☐ Nightmares
☐ Sadness/Depression	☐ Difficulty with Parents	☐ Nausea
☐ Mood Changes	☐ Difficulty with Children	☐ Abdominal Distress
☐ Easily Angered or Bad Temper	☐ Marriage/Partnership conflict	☐ Fainting
☐ Panic	☐ Problems with friends	☐ Dizziness
☐ Fears	☐ Problems with coworkers	☐ Shortness of breath
☐ Irritability	☐ Employer	☐ Chest pain
☐ Poor concentration	☐ Finances	☐ Sweating
☐ Headaches	☐ Legal problems	☐ Heart palpitations
☐ Loss of memory	☐ Sexual concerns	☐ Muscle tension
☐ Excessive worry	☐ Grief	☐ Fidgeting
☐ Manic or elevated mood	☐ History of child abuse	☐ Hyperactivity
☐ Difficulty trusting others	☐ Domestic violence	☐ Chills or hot flashes
☐ Difficulty communicating	☐ History of sexual abuse/rape	☐ Easily distracted
☐ Drugs	☐ Thoughts of hurting someone	☐ Careless mistakes
☐ Excessive alcohol	☐ Thoughts of suicide	☐ Frequent crying
☐ Excessive caffeine	☐ Sleeping too much	☐ Severe weight gain