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INTAKE FORM

Please complete the form below or if you prefer, we can complete it together in the first session.

What brings you in to therapy at this time? What are the main goals or issues you would like to address?

Please check if you are experiencing any of the following symptoms:

- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth, harsh self-talk
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Difficulty concentrating
- ☐ Indecisiveness
- ☐ Anxiety/excessive worry
- ☐ Compulsive, intrusive thoughts
- ☐ Panic attacks
- ☐ Fear when away from home
- ☐ Social discomfort or phobia
- ☐ Other kind of phobia

- ☐ Irritability or anger
- ☐ Aggression, frequent fights
- ☐ Anger outbursts
- ☐ Flashbacks
- ☐ Recurring, disturbing memories
- ☐ Physical reaction to memories
- ☐ Overwhelming emotions
- ☐ Hyper vigilant
- ☐ Nightmares
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors
- ☐ Feeling paranoid or suspicious
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Hearing voices/audible hallucinations
- ☐ Visual hallucinations
- ☐ Other symptom: _____
  _____

Problems related to:

- ☐ Eating:
  - ☐ low appetite/digestion problems
  - ☐ overeating
- ☐ Sleep:
  - ☐ too much
  - ☐ not enough
  - ☐ reduced need for sleep
- ☐ Chronic illness or pain
- ☐ Work/School
- ☐ Identity
- ☐ Finances
- ☐ Relationships
- ☐ Parenting
- ☐ Sex
- ☐ Sexuality
- ☐ Health
- ☐ Spirituality
- ☐ Other _____
  _____

Comments:

Please indicate where there are or have been safety concerns:

	Never	Past	Recent	Comments
Thoughts of death or suicide:	☐	☐	☐	
Attempted suicide:	☐	☐	☐	
Self-injury (cutting, hitting):	☐	☐	☐	
Risk-taking behaviors:	☐	☐	☐	
Abuse or harm from another person:	☐	☐	☐	
Thoughts of harm to others:	☐	☐	☐	
Actual harm to others:	☐	☐	☐	
Other _____:	☐	☐	☐	

Past experiences with mental health treatment (counseling, groups, hospital, medications, etc.)

Do you have any concerns about starting therapy now?

Check the events you have experienced and feel were traumatic to you:

- ☐ Loss of a loved one
- ☐ Crime victim
- ☐ Victim of abuse as child: emotional, sexual, physical
- ☐ Neglect as a child
- ☐ Substance abuse by parent
- ☐ Oppression _____
- ☐ Domestic Violence
- ☐ Witness to violence, crime, or abuse of someone else
- ☐ Medical procedure (surgery, etc.)
- ☐ Accident (car, bike, natural disaster, etc.)
- ☐ Extreme financial problems, food scarcity
- ☐ Ancestral or community trauma
- ☐ Other: _____

Comments:

Is there any history in your family of mental health problems? ☐ Yes ☐ No If yes, please describe:

Please describe your use of alcohol and/or drugs:

Type	Amount	Frequency	Current / how long ago?

Comments:

Have you had problems with any other kind of addiction?
☐ Gambling ☐ Internet or computer ☐ Pornography ☐ Other _____

Comments:

Medical History, health concerns, pain, injuries, etc.

What treatments or healing practices are you involved with?

Current prescription medications, over-the-counter medications, remedies, or herbs you are taking:

Medicine/remedy	Dosage (if known)	For what purpose?

Comments:

Current living situation:

Employment/Education history & current situation:

How do you spend your time?

What helps you the most? Who are your support people?

What else is important for me to know about you before we begin working together?