PSYCHOLOGY PRIVATE PRACTICE
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Intake Form

Please answer the questions below:

1. Have you been experiencing mental health symptoms like depressed mood, anxiety or other symptoms? Yes ( ) No ( )

If yes, which one(s)? _____

2. Have you ever been hospitalized for a psychiatric issue? Yes ( ) No ( ). If yes, which one(s)? _____

3. Is there a history of mental health problems in your family? Yes ( ) No ( ). If yes, which family member and which one(s)? _____

_____

4. If you are in a relationship, please describe the nature of the relationship and months or years together.

_____

_____

5. Please describe your current living situation. Do you live alone, with others? With whom?

_____

_____

6. What is your level of education, degree and degree type?

_____

_____

7. What is your current profession/occupation and how long have you been doing it?

_____

_____

8. Please check any of the following symptoms you may have experienced in the past six months:

Increased appetite [ ]

Decreased appetite [ ]

Trouble concentrating [ ]

Difficulty sleeping [ ]

Excessive sleep [ ]

Low motivation [ ]

Isolation from others [ ]

Fatigue/low energy [ ]

Low self-esteem [ ]

Depressed mood [ ]

Tearful or crying spells [ ]

Anxiety/worry [ ]

Fear [ ]

Hopelessness [ ]

Panic [ ]

Other:

_____

Please check any of the following symptoms you may have experienced in the past or that are current:

Headache [ ]

High blood pressure [ ]

Gastritis or esophagitis [ ]

Hormone-related problems [ ]

Head injury [ ]

Angina or chest pain [ ]

Irritable bowel [ ]

Chronic pain [ ]

Loss of consciousness [ ]

Heart attack [ ]

Bone or joint problems [ ]

Seizures [ ]

Kidney-related issues [ ]

Chronic fatigue [ ]

Dizziness [ ]

Faintness [ ]

Heart valve problems [ ]

Urinary tract problems [ ]

Fibromyalgia [ ]

Numbness & tingling [ ]

Shortness of breath [ ]

Diabetes [ ]

Hepatitis [ ]

Asthma [ ]

Arthritis [ ]

Thyroid issues [ ]

HIV/AIDS [ ]

Cancer [ ]

Other: _____

9. What other medical or mental health issues would you like to let me know about?

_____

_____

10. What brings you to counselling? Is there a particular event? Please be detailed:

_____

_____

_____

_____

11. What are your goals for counseling? We will be discussing goals a number of times.

_____

_____

_____

12. Have you seen a mental health professional before? Yes ( ) No ( )

If yes, whom? What for? Can you please provide his/her contact information?

_____

_____

13. Please specify all prescribed medications and supplements, doses, and for what reasons:

_____

_____

14. If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number:

_____

_____

15. Who is your primary care physician? Please include type of MD, name and phone number.

_____

_____

16. Do you drink alcohol? Yes ( ) No ( )

If yes, what do you drink and what are the amounts and frequencies? Has been a problem for you?

_____

_____

17. Do you use recreational drugs? Yes ( ) No ( )

If yes, what drugs, amounts and frequencies? Has it been a problem for you?

_____

_____

18. Do you have suicidal thoughts? Yes ( ) No ( )

If yes, what thoughts and what frequency?

_____

_____

19. Have you ever attempted suicide? Yes ( ) No ( )

If yes, what happened, and when?

_____

_____

20. Do you have thoughts or urges to harm others? Yes ( ) No ( )

If yes, whom?

_____

_____