INTAKE

Appt Date: _____/_____/_____
(yy) (mm) (dd)

Name _____

Address _____

Phone Nbr(s) _____

Email _____

DOB _____/_____/_____
(yy) (mm) (dd)

Occupation _____

Education _____

Name of partner or spouse _____
(or parent/guardian)

Length of relationship _____

Relevant Family Members (eg, living in the family home):

_____ _____

_____ _____

Issues you would like to address in therapy

_____

_____

_____

_____

_____

ADDITIONAL INFO Appt Date: _____/_____/_____
(yy) (mm) (dd)

Name _____

Medications: Condition: Duration:

_____

_____

_____

_____

_____

Referred by _____

GP _____

Current / previous therapists seen (helpful? Not helpful?)

_____

Suicide Attempts: Yes _____ No _____ Ideation: Yes _____ No _____

(Details) _____

Health Checklist (check all that apply)

Anxiety _____ Depression _____ Stress _____ Pain _____

Alcoholism _____ Workaholism _____ Other addictions _____

Weight/dieting _____ Sleep problems _____ Anger _____

Relationship problems _____ Interpersonal or family difficulties _____

Other health problems _____