## **Psychotherapy Intake Form**

Personal information		
Full name:	Date of birth:	
Sex:	Occupation:	
Address:		
Phone number:	Email address:	
Referral (if applicable):		
Emergency contact:		
Medical information		
Primary care physician:		
Primary care physician contact number:		
Do you have current medical/health concerns?	If yes, please list:	
☐ Yes		
□ No		
Are you currently taking any prescription medication?	If yes, please list:	
☐ Yes		
□ No		
Psychological information		
Are you currently receiving psychological services (e.g., professional counseling, psychiatric services, or any other mental health services)?	If yes, please explain your situation:	
☐ Yes		
□ No		
Are you currently taking any psychiatric prescription medication?	If yes, please list:	
☐ Yes		
□ No		

Have you been prescribed psychiatric prescription medication in the past?	If yes, please list:
☐ Yes	
□ No	
Have you been psychiatrically hospitalized in the past?	If yes, please explain:
☐ Yes	
□ No	
Symptoms	
Please check the symptoms that you have experie	enced in the past two weeks:
☐ Depressed mood	☐ Repetitive behaviors
☐ Panic attacks	☐ Eating difficulties
	<ul><li>Anxiousness</li></ul>
☐ Interpersonal difficulties	☐ Alcohol/drug usage
☐ Mood swings	☐ Phobias
☐ Sleep difficulties	☐ Somatic complaints
☐ Hallucinations	☐ Difficulty concentrating
Have you had suicidal thoughts in the past two	If yes, how often?
weeks?	☐ Frequently
☐ Yes	☐ Sometimes
□ No	☐ Rarely
Have you had suicidal thoughts in the past year?	If yes, how often?
☐ Yes	☐ Frequently
☐ No	□ Sometimes
	☐ Rarely

Family mental health history		
Have any of your family members had any of the following issues?		
Depression Anxiety Panic attacks Eating disorder Sexual abuse Schizophrenia  Goals for psychotherapy What would you like to achieve through therapy?	Suicide Bipolar personality disorder Alcohol/substance abuse Trauma Obsessive-compulsive disorder Other:	
What are your hopes and expectations for working	with a therapist?	
Additional notes		