I N T A K E F O R M

Please provide the following information and answer the questions below to the best of your ability. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: ____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____

(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: _____________

My current gender identity is: _____________ My sexual orientation is:_____________ My sex assigned at birth is: ___________ My pronouns are: _________________

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed
Please list any children/age: ____

Address: ____ (Street and Number) ____ (City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: ____________________________________ May we email you? □ Yes □ No *Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner: ______________________________________

Are you currently taking any prescription medication? □ Yes □ No Please list:

____

____

Silvia DaRe, LMFT

Silvia DaRe, Licensed Marriage & Family Therpist (LMFT)
(206)-366-5541 *Email: slv.dare@gmail.com*

Have you ever been prescribed psychiatric medication? □ Yes □ No Please list and provide dates:

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle) Poor Unsatisfactory Satisfactory Good Very good Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle) Poor Unsatisfactory Satisfactory Good Very good Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? __________ What types of exercise to you participate in __________________________________

4. Please list any difficulties you experience with your appetite or eating patterns

____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes If yes, for approximately how long? ________________________

6. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes If yes, when did you begin experiencing this? ___________________________

7. Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe

____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? __________________

On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently:

____

ADULT CHECKLIST OF CONCERNS

Please mark all of the items below that are of concern for you. You may add a note or details in the space next to the concerns checked.

___Abuse - victim of physical, sexual, and/or emotional abuse or neglect

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___Aggression, violence

___Alcohol, violence

___Anger, hostility, arguing, irritability

___Anxiety, nervousness

___Attention, concentration, distractibility

___Career concerns, goals, and choices

___Childhood issues (your own childhood)

___Children, child management, child care, parenting

___Codependence

___Confusion

___Compulsions

___Custody of children

___Decision making, indecision, mixed feelings, putting off decisions

___Delusions (false ideas)

___Dependence

___Depression, low mood, sadness, crying

___Divorce, separation

___Drug use - prescription medications, over-the-counter medications, street drugs

___Eating problems - overeating, undereating, appetite, vomiting

___Emptiness

___Failure

___Fatigue, tiredness, low energy

___Fears, phobias

___Financial or money troubles, debt, impulsive spending, low income

___Friendships

___Gambling

___Grieving, mourning, deaths, losses, divorce

___Guilt

___Headaches, other kinds of pains

___Health, illness, medical concerns, physical problems

___Inferiority feelings

___Interpersonal conflicts

___Irresponsibility

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___Impulsiveness, loss of control, outbursts

___Judgment problems, risk taking

___Legal matters, charges, suits

___Loneliness

___Marital conflict, distance/coldness, infidelity/affairs, remarriage

___Memory problems

___Menstrual problems, PMS, menopause

___Mood swings

___Motivation, laziness

___Nervousness, tension

___Obsessions, compulsions (thoughts or actions that repeat themselves)

___Over sensitivity to rejection

___Panic or anxiety attacks

___Perfectionism

___Cruelty to animals

___Procrastination, work inhibitions, laziness

___Relationship problems

___School problems

___Self-centeredness

___Self-esteem

___Self-neglect, poor self-care

___Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)

___Shyness, over sensitivity to criticism

___Sleep problems - too little, insomnia, nightmares

___Smoking and tobacco use

___Stress, relaxation, stress management, stress disorders, tension

___Suspiciousness

___Suicidal thoughts

___Temper problems, self-control, low frustration tolerance

___Thought disorganization and confusion

___Threats, violence

___Weight and diet issues

___Withdrawal, isolating

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___Work problems, employment, workaholism/overworking, can't keep a job

Please look back over the concerns you have checked off and choose the top three that you most want help with and why (briefly). They are:

____

____

____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	**List Family Member**
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation:

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

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2. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths?

____

____

____

____

4. What do you consider to be some of your weakness?

____

____

____

____

5. What would you like to accomplish out of your time in therapy?

____

____

____

Printed name

____

Signature Date:

____

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