INTAKE FORM

Contents of all therapy sessions

Please note: information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell Phone: _____May we leave a message? ☐ Yes ☐ No

Email: _____ May we Email you? ☐ Yes ☐ No

***Please note:** Email correspondence is not considered to be a confidential medium of communication.

Referred by: _____

Area of concern or problems that bring you to Therapy: _____

_____

_____

GOALS you would like to address in Therapy:

1. (primary goal) _____
2. _____
3. _____

How will you know when you have reached your goals? _____

_____

What have you done in the past that you found helpful? _____

_____

RELATIONSHIPS

Your Relationship Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced

☐ Widowed How Many Years? _____

On a scale of 1-10 (10 being great), how would you rate your relationship? _____

If you have children, list gender & ages, and/or others present in your household:

_____

_____

Other relationship concerns: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   List any specific health problems you are currently experiencing:

_____

2. Are you currently experiencing any chronic pain? ☐ Yes, please describe below ☐ No

_____

3. How many times per week do you generally exercise? _____

   What types of exercise do you participate in? _____

4. Are you currently experiencing any of the following symptoms? (please circle):

Anxiety	Depression	Memory Difficulties
Panic	Loss of Interest	Anger
Loss of Appetite	Agitation	Helplessness
Dizziness	Too little sleep	Procrastination
Compulsions	Too much sleep	Confusion
Social Withdrawal	Hearing Voices	Easily Tearful
Obsessiveness	Loneliness	Visual Hallucinations
Sadness	Lack of Concentration	Thoughts that scare you
Grief	Difficulty initiating activity	Fatigue
Fear	Weight Gain	Excessive happiness
Nightmares	Weight Loss	Increased Disorganization
Impulsiveness	Outbursts	

Rate (circle) your mood on a 0/10 scale: LOW < 1 2 3 4 5 6 7 8 9 10 >HIGH

5. Have you ever had a head injury, concussion (either a blow to the head, or sudden deceleration or violent shaking) in which you: (circle all that apply):

A. Lost consciousness
B. your consciousness was altered (your "bell was rung")
C. you or others noticed that you seemed different afterwards
D. your cognition or memory changed

When and how did this concussion or head injury occur? _____

_____

6. Have you previously received any type of mental health services (psychotherapy, couples counseling, psychiatric services, etc.)? ☐ Yes ☐ None

If Yes, **previous** therapist/practitioner & dates:

_____

Previous Psychiatric Hospitalizations? ☐ Yes ☐ None

If Yes, previous hospitals & dates:

_____

Current prescription for mental health medication? ☐ Yes ☐ None

If Yes, please list:

_____

Previous prescription for mental health medication? ☐ Yes ☐ None

If Yes, please list:

_____

Any current or past natural or alternative meds, supplements or mental health treatments?

☐ Yes ☐ No

If Yes, please list and provide dates (circle those that you found most helpful):

_____

_____

7. If you drink alcohol, please note the type, amount and how many times per week.

_____ ☐ I do not drink.

8. If you use recreational drugs, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

What types _____

9. Have you had any inpatient or outpatient treatment for alcohol or drug use?

_____

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(s)
Alcohol/Substance Abuse	Yes / No	_____
Anxiety	Yes / No	_____
Depression	Yes / No	_____
Domestic Violence	Yes / No	_____
Eating Disorders	Yes / No	_____
Obsessive Compulsive Behavior	Yes / No	_____
Other Mental Diagnosis	Yes / No	_____
Suicide Attempts	Yes / No	_____

ADDITIONAL INFORMATION

1. Are you currently employed? ☐ Yes ☐ No

If Yes, what is your current employment situation: _____

Do you enjoy your work? Is there particular stress or problems in your current work?

_____

2. Highest Grade completed in school or college? _____

3. Favorite interests, activities or experiences? _____

_____

4. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If Yes, describe your spirituality, faith or belief if you would like:

_____

5. What do you like most about yourself or consider to be your best attributes?

_____

_____

6. Are there any concerns about self esteem or things about yourself you do not like?

_____

_____

7. Is there anything else you would like the Therapist to know? _____

_____

_____

I understand that completion of the above is for informational purposes and does not constitute a contract for services as further therapy concerns are generally addressed during the first appointment.

I agree to pay for sessions at the time of the appointment. If insurance is being utilized, I agree that it is my responsibility to understand my coverage, co-pays and deductibles, if any. The billing of insurance by the provider is a courtesy and I am ultimately responsible for payment of services provided.

_____

Name Printed

_____ _____

Signature Date

Please mail to:

New Life Harmony, LLC
1607 24th Ave., Suite A
Gulfport, MS 39501