THERAPY INTAKE FORM

DEMOGRAPHICS:

Name: _____ **Date of Birth** _____/_____/_____

Identified Gender: _____ **Race:** _____ **Marital Status:** _____

Address: _____ **Phone Number:** _____

_____ **Other Ph. Number:** _____

Permission to Call: ☐ **Yes** ☐ **No** **Restrictions:** _____

Email: _____

Emergency Contact Name: _____ **Number:** _____

Parent/Gaudian Name (if applicable) _____

Parent/Gaudian Phone (if appliable) _____

INSURANCE:

Primary Insurance: _____ **Phone:** _____

Insured Name: _____ **DOB:** _____ **SSN #:** _____

ID#: _____ **Group:** _____

Employer: _____

Secondary Insurance: _____ **Phone:** _____

Insured Name: _____ **DOB:** _____ **SSN #:** _____

ID#: _____ **Group:** _____

Employer: _____

Availability:

Please list days/times you are available. Note that that reduced availability and evening hours will result in significant wait times to initiate therapy.

Monday ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday** ☐

Morning ☐ **Afternoon** ☐ **Evening** ☐

Reason for Seeking Treatment

CURRENT OR PAST CONCERNS:

Diagnosis/Concern	Now	Past	Comments
Depression	☐	☐	
Anxiety	☐	☐	
Mood Disorder	☐	☐	
Anger Management	☐	☐	
Bipolar Disorder	☐	☐	
Suicidal Ideations or Attempts	☐	☐	
Substance Abuse	☐	☐	
Paranoia / Hallucination	☐	☐	
Schizophrenia	☐	☐	
Eating Disorder	☐	☐	
Trauma	☐	☐	
Emotional/Verbal Abuse	☐	☐	
Sexual Abuse	☐	☐	
Physical Abuse	☐	☐	
Attention Deficit Disorder	☐	☐	
Obsessive Compulsive Disorder	☐	☐	
Autism	☐	☐	
Relationship Distress/Marital Issues	☐	☐	

CURRENT MEDICATIONS:

Medication	Dosage/Frequency	Condition	Prescriber

MEDICAL

Do you have any current physical problems or concerns? ☐ Yes ☐ No

If yes, please specify concerns:

_____

Past or current medical issues:

Medical issues	Current	Past	Details:
Heart Problems	☐	☐	
High or Low Blood Pressure	☐	☐	
Stroke	☐	☐	
Cancer (Type)	☐	☐	
Arthritis	☐	☐	
Epilepsy	☐	☐	
Diabetes	☐	☐	
Anemia	☐	☐	
Kidney Problems	☐	☐	
Eye/Eat Problems	☐	☐	
Liver Conditions	☐	☐	
Lung/Breathing Problems	☐	☐	
Thyroid Conditions	☐	☐	
Sexually Transmitted Disease(s)	☐	☐	
Other:	☐	☐	

Previous Surgeries: ___ Yes ___ No

If yes, specify: _____

Previous Hospitalizations: ____ Yes ____ No

If yes, specify: _____

GAD-7 Anxiety

Over the last TWO WEEKS, how often have you been bothered by the following problems?	Not at all 0	Several Days 1	More than half the days 2	Nearly Every day 3
Feeling nervous, anxious, or on edge?	○	○	◉	○
Not being able to stop or control worrying	○	◉	○	○
Worrying too much about different things	○	○	○	○
Trouble relaxing	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○
Feeling afraid, as if something awful might happen	○	○	○	○

Column Totals _____ + _____ + _____ + _____

= Total Score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very Difficult
- ☐ Extremely Difficult

PHQ-9

Over the last TWO WEEKS, how often have you been bothered by any of the following problems?	Not at all 0	Several Days 1	More than half the days 2	Nearly Every day 3
Little interest or pleasure in doing things?	○	○	○	○
Feeling down, depressed, or hopeless?	○	○	○	○
Trouble falling or staying asleep or sleeping too much?	○	○	○	○
Feeling tired or having little energy?	○	○	○	○
Poor appetite or overeating?	○	○	○	○
Feeling bad about yourself – or that you are a failure or have let yourself or family down?	○	○	○	○
Trouble concentrating on things, such as reading or watching television?	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or being so fidgety or restless that you have been moving around more than usual?	○	○	○	○
Thoughts that you would be better off dead, or of hurting yourself in some way?	○	○	○	○

Column Totals _____ + _____ + _____ + _____

= Total Score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very Difficult
- ☐ Extremely Difficult