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Intake Form

Welcome to my Office!

Confidential Client information: **PLEASE PRINT CLEARLY** Today's Date: _____

I have some initial questions for you, followed by some things that I want you to know about my practice. This is meant to inform you and to get your consent to work together. **THIS IS MY INTAKE FORM**. I'll need to have this filled out and for us to discuss this by the end of our first session.

Your Name: _____ _____ Female _____ Male

Who referred you? _____

Address: _____

City: _____ Zip: _____

Cell Phone _____ Is it OK to call/text you here? _____

Home Phone _____ Is it OK to call you here? _____

Work Phone _____ Is it OK to call you here? _____

Email _____ Is it OK to email you? _____

For purposes of scheduling, may we correspond via email/texting? Yes _____ No _____

If you are seeing me for addictive (alcohol/drug/sex/gambling) behaviors, may we correspond via email/texting for purposes of brief check ins? Yes _____ No _____

PLEASE NOTE: Email and texting as correspondence are not considered to be confidential medium of communication.

Social Security #:_____ Drivers License # _____

Date of Birth: _____ Age: _____

What was one or two of your favorite TV programs you watched growing up _____

_____

What was one or two of your favorite musical artists? _____

Childhood Religion or Spirituality? _____

Current Religion or Spirituality? _____

How do you Identify Culturally, Racially, Socially? _____

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IN CASE OF EMERGENCY (ICE)

Emergency Contact Name: _____

Emergency Contact Phone: _____

Emergency Contact Email: _____

MEDICAL QUESTIONS

Who is your medical doctor and/or psychiatrist? _____

What is his/her phone number? _____

What are your current physical health considerations (illnesses, conditions, allergies, etc.) that affect you? _____

_____

What medications are you currently taking? _____

_____

What non prescription health aids (herbs, vitamins, remedies, etc...) are you currently taking? _____

_____

Have you ever *felt like* you wanted to end your life? _____ Yes _____ No

If yes, have you felt this way in the past ☐ week ☐ month ☐ year

Have you ever *attempted* to end your life? If yes, what happened, when? _____

_____

Have you ever been to a therapist before? _____

If yes, what worked (and what DIDN'T?) _____

_____

EMPLOYMENT QUESTIONS

Are you currently employed? _____ What is your occupation? _____

What do you like/dislike about your work? _____

_____

_____

Would you say that at your work you're __ employed & satisfied __ employed but dissatisfied

__ unemployed __ coworker conflicts __ supervisor conflicts __ unstable work history

__ disabled

Please Initial that this data is true for you _____

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RECREATION QUESTIONS

What do you do for fun, to let off steam, cut loose, to relax? _____

_____

LIFESTYLE AND SOCIAL/RELATIONSHIP QUESTIONS

How would you rate your sleeping habits right now (circle one)?

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your nutrition (eating) habits right now (circle one)?

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your exercise habits right now (circle one)?

Poor Unsatisfactory Satisfactory Good Very good

ANY CHANGES IN:

Sexual Drive/Behavior _____

Appetite/Eating Behavior _____

Sleep/Dreaming Behavior _____

RELATIONSHIP STATUS/QUESTIONS:

Are you (circle one): Single Partnered/Dating Married Divorced Widowed Other

Name of Partner: _____How long have you been together? _____

How many relationships have you had? _____ Is your partner a different sero-status than you? _____ Yes _____ No

Regarding your intimate relationships, please mark which best applies to you:

_____ never been in a serious relationship
_____ not currently in a relationship
_____ currently in a serious relationship

_____ **very satisfied** with relationship
_____ **satisfied** with relationship

_____ ***somewhat satisfied*** with relationship
_____ ***dissatisfied*** with relationship
_____ ***very* dissatisfied** with relationship

Do you: _____ live alone _____ live with intimate partner _____ live with a roommate(s)

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Please place a checkmark or X on any items that apply to you

- ☐ Too few friends
- ☐ I'm overly shy
- ☐ I find it difficult to open up to others
- ☐ I make friends easily
- ☐ Others seem to be picking on me
- ☐ I talk to friends about problems
- ☐ I prefer to hang out with one person
- ☐ I feel invisible
- ☐ I have a supportive social network
- ☐ I have substance-use based friends
- ☐ I have enough friends
- ☐ I have no friends
- ☐ I find it hard to find friends
- ☐ I find it hard to keep friends
- ☐ No one really seems to understand me
- ☐ I don't talk to friends about problems
- ☐ I prefer to hang out with groups
- ☐ I don't have a lot of friends
- ☐ I have sex-use based friends
- ☐ I isolate quite a bit

FAMILY OF ORIGIN QUESTIONS

Place of birth: _____

How would you describe your childhood (0-10 years) _____

_____

_____

Any birth complications? _____ Yes _____ No If yes, what were they? _____

Number of years with "nuclear" (the family you grew up with when you were a kid) family? _____

History & current relationship with father (if deceased, how old were you when this happened)? _____

_____

History & current relationship with mother (if deceased, how old were you when this happened)? _____

_____

History & current relationship with siblings? _____

_____

Any sexual trauma or manipulation (abuse, molestation, rape, abortion, emotional innuendos by close relatives) towards you in your history? _____ Yes _____ No

History of traumatic events (family violence, war, deaths, divorces, assaults, date rapes, etc...) _____

_____

_____

_____

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SEXUAL QUESTIONS

Check which fits you most accurately:

Your sexual partners are:
__ men __ women __ both

__ heterosexual orientation
__ homosexual orientation
__ bisexual orientation
__ bisexual primarily heterosexual
__ bisexual primarily homosexual
__ currently sexually active (y/n)
____ currently sexually *satisfied* (y/n)
____ currently sexually *dissatisfied* (y/n)

How old were you when you first had sex?
_____ years old

How old was your *partner* when you first had sex? _____

Do you have pain during intercourse?
_____ yes _____ no If yes, please describe: _____
_____
_____

Any difficulties with penile erection or ejaculation? ___ yes ___ no
If yes, please describe: _____
_____
_____

Age of your first pregnancy/fatherhood?
_____

FOR COUPLES: What stops you and your partner from having great sex?
_____
_____
_____
_____

What would your *partner* say stops you?
_____
_____
_____

Did you use condoms with your partner(s) in the past year?
__ Always __ Most of the time __ Sometimes __ Never

With your *last* partner? __ yes__ no

Do you have concerns about your sexual activities? __ yes __ no

Do *others* have concerns about your sexual activities? __ yes __ no

Would it be accurate that you are having problems with your sexual actions but don't consider yourself a "sex addict?" __ yes __ no

Do you often find yourself preoccupied with sexual thoughts?
__yes __no

Have your sexual actions (either with others or by yourself) created problems for you, your family or your friends? __ yes __ no

Do you feel controlled by your sexual desires/actions?
__ Always __ Most of the time __ Sometimes __ Never

Have you ever felt degraded by your sexual behaviors?
__ Always __ Most of the time __ Sometimes __ Never

Do you ever think your sexual desire is stronger than you are?
__ Always __ Most of the time __ Sometimes __ Never

Do you think that casual or anonymous sex has kept you from having more long-term intimate relationships? __ yes __ no

Have you ever had unsafe or "risky" sex even though you knew it could cause you harm? __ yes __ no

After having a lot of sex, do you sometimes refrain from all sex for a significant amount of time? __ yes __ no

Do you ever feel depressed or guilty after having sex? __ yes __ no

Do you ever wish you could stop your sexual behavior __ yes __ no

Do you ever use sex to "numb out?" __ yes __ no

Do you ever hide your sexual behaviors from others? __ yes __ no

Have your made efforts to quite a type of sexual activity and failed?
__ yes __ no

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DRUG/ALCOHOL/OUT OF CONTROL SEX QUESTIONS

How often do you drink caffeinated products?

☐Daily ☐ Weekly ☐Monthly ☐Infrequently ☐ Never

How often do you drink alcohol?

☐Daily ☐ Weekly ☐Monthly ☐Infrequently ☐ Never

In the *past*, what was the *most* that you ever drank alcohol?

☐Daily ☐ Weekly ☐Monthly ☐Infrequently ☐ Never

Do you, *or,* anyone *you know* ever have concerns about your alcohol, drug, or sexual behaviors? _____ Yes _____ No

How often do you engage in recreational drug use?

☐Daily ☐ Weekly ☐Monthly ☐Infrequently ☐ Never

How often do you engage in sexual actions (porn, hookups, chat rooms, self pleasuring, etc...) that you *say* you don't want to do, but you really *do* engage in?

☐Daily ☐ Weekly ☐Monthly ☐Infrequently ☐ Never

What's your drug of choice (meth, bourbon, porn, soda, sex, chocolate etc...)? _____

Ever been to a 12 Step meeting including an "S" meeting? If yes, which one(s), and what are/were the benefits that you found from attending (if any)? _____

Did anyone in your *family* abuse alcohol/drugs?

__ father __ mother __ grandparent(s) __ sibling(s) __ stepparent __ uncle(s)/aunt(s)
__ spouse __ significant other __ children

Substance use: for you
__ no history
__ active abuse
__ early full remission
__ early partial remission
__ sustained full remission
__ sustained partial remission
Treatment history -- for you
__ outpatient (ages) _____
__ inpatient (ages) _____
__ stopped on own (ages) _____

Consequences of substance abuse or sexually acting out:
__ hangovers __ withdrawal symptoms __ sleep disturbance __ binges
__ seizures __ medical conditions __ assaults __ job loss
__ blackouts __ tolerance changes __ suicidal impulse __ arrests
__ overdose __ loss of control of amount used __ loss of relationship
__ loss of friends __ increased isolation

__ other _____
_____
_____
_____

Please Initial that this data is true for you _____

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Alcohol/drug treatment history: Complete all that apply to you:	First usage age	Last use age	**Current Use Yes/No**	Frequency	Amount
___ alcohol	_____	_____	_____	_____	_____
___ amphetamines/speed	_____	_____	_____	_____	_____
___ barbiturates/owners	_____	_____	_____	_____	_____
___ caffeine/caffeinated products	_____	_____	_____	_____	_____
___ cocaine	_____	_____	_____	_____	_____
___ crack cocaine	_____	_____	_____	_____	_____
___ hallucinogens	_____	_____	_____	_____	_____
___ inhalants (e.g. glue, gas, poppers)	_____	_____	_____	_____	_____
___ marijuana/hashish	_____	_____	_____	_____	_____
___ nicotine/cigarettes	_____	_____	_____	_____	_____
___ PCP	_____	_____	_____	_____	_____
___ prescription	_____	_____	_____	_____	_____
___ other.	_____	_____	_____	_____	_____

Who was present during your childhood? (Mark an X or a Checkmark √ where it fits best)

	Present entire childhood	Present *part* of childhood	*Not* present at all during childhood
mother	_____	_____	_____
father	_____	_____	_____
stepmother	_____	_____	_____
stepfather	_____	_____	_____
brother(s)	_____	_____	_____
sister(s)	_____	_____	_____

How was your childhood family experience?
_____ outstanding home environment
_____ normal home environment
_____ neglectful home environment (parents weren't around)
_____ chaotic home environment (didn't know what to expect next)
_____ witnessed physical/verbal/sexual abuse toward others
_____ experienced physical/verbal/sexual abuse from others

How old were you when you were emancipated or left home? _____ What were the circumstances of you leaving home?

_____

_____

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Below, please 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)

	Please Circle		Family Members involved
Alcohol/Substance problems	yes	no	_____
Anxiety	yes	no	_____
Depression	yes	no	_____
Domestic Violence	yes	no	_____
Eating Disorders	yes	no	_____
Obesity	yes	no	_____
Obsessive Compulsive Behavior	yes	no	_____
Rage	yes	no	_____
Schizophrenia	yes	no	_____
Sexual acting out	yes	no	_____
Suicide Attempts	yes	no	_____
Violence	yes	no	_____

STRESS AND ANGER

CURRENT SOURCES OF STRESS
Please list the things/events/problems that are *stressful* in your life at the present time (include significant losses and changes in your life)

1._____

2._____

3._____

ANGER
Please list things/events/problems that are evoking *anger* in your life at the present time

1._____

2._____

3._____

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Now...
Please list things/events/problems that ***used to*** evoke anger in your life ***when you were a kid.***

1._____

2._____

3._____

HAVE I MISSED ANYTHING?
Is there something MEDICALLY that I've not asked and it would help our work if you told me? Have I missed something that's NOT medical but its important? What is it?

- _____
- _____
- _____

AND FINALLY...

List Three STRENGTHS that you have

1. _____
2. _____
3. _____

What brings you in? Why are you here? _____

_____

_____

What's the *history* of this issue, and, why come in *now*?

_____

_____

_____ _____

Please **print your name clearly** Date

_____ _____

Please **sign** your name Date

Please Initial that this data is true for you _____