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INTAKE FORM

Please complete this secure form before your first appointment. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. During our first in-person appointment I will inquire further into certain areas as needed. Please let me know if you have any questions or concerns when completing this form. Finally, please feel free to add any additional information you think is important for me to know.

Demographic Information

Name: _____

Street Address: _____

City: _____ Zip Code: _____

Primary Contact #: _____ Alternate #: _____

Okay to leave a voicemail message? ☐ Yes ☐ No

Email Address: _____ SSN: _____

Age: _____ DOB: _____ Race/Ethnicity: _____

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Relationship: _____

Telephone (Day): _____ (Evening): _____

Street Address: _____

City: _____ Zip Code: _____

Mental Health History

Referred by:
☐ Medical Provider: _____
☐ Website at (www.drerinjoyce.com)
☐ Psychology Today website
☐ Friend/Family: _____

Briefly, what brings you in to therapy now? _____

_____

When did your problem(s) first start? Within the last:

☐ 30 days ☐ 6-12 months ☐ 2 years ☐ During adolescence ☐ During childhood

What areas of your life have been affected because of this problem? _____

_____

Have you previously received any type of mental health services either for this problem(s) or others?
☐ No ☐ Yes

If yes, which of the following:

☐ Psychotherapy ☐ Psychiatric Medication ☐ Outpatient hospitalization or day treatment program ☐ Inpatient hospitalization

Please briefly explain the reason for seeking treatment. _____

Are you currently experiencing overwhelming sadness, grief or depression?
☐ No
☐ Yes
If yes, for approximately how long? _____

If yes, have you felt so badly that you've had thoughts of not wanting to be here anymore or of killing yourself?
☐ No
☐ Yes

Do you have a history of suicidal thoughts or any suicide attempts?
☐ No
☐ Yes
If yes, please explain. _____

Do you have a history of engaging in any self-harm behaviors, e.g., cutting?
☐ No
☐ Yes
If yes, please explain. _____

Are you currently experiencing anxiety, panic attacks or any phobias?
☐ No
☐ Yes

If yes, since when? _____

Have you experienced any abuse or traumatic events in your life?
☐ No
☐ Yes

If yes, please describe briefly if you feel comfortable doing so. _____

_____

Have you experienced any significant losses at any point in your life?
☐ No
☐ Yes

If yes, please explain briefly. _____

_____

Please describe current use of alcohol, tobacco, and/or recreational drugs:

_____

Please describe any previous use of alcohol, tobacco, and/or recreational drugs:

_____

Do you have a history of any physical violence or assault towards others?
☐ No
☐ Yes

Do you have a history of any significant legal problems, e.g., court-mandated therapy or mental health treatment, arrests, lawsuits (either as plaintiff or defendant)?
☐ No
☐ Yes

Have you experienced any significant life changes or stressful events recently?

_____

_____

What are the main ways you cope with stress? _____

_____

Family & Relationship History

Briefly describe your upbringing (parents/caregivers, siblings, home environment, school performance, any abuse, other significant events). _____

_____

Any family history of mental illness?
☐ No
☐ Yes

Any family history of suicide?
☐ No
☐ Yes

Sexual Orientation:
☐ Heterosexual
☐ Gay/Lesbian
☐ Bisexual
☐ Other: _____

Relationship Status (Please check all that apply.):
☐ Single
☐ In a relationship
☐ Married
☐ Domestic Partner
☐ Separated
☐ Divorced

☐ Widowed

If applicable, on a scale of 1-10 (best), how would you rate your relationship?

_____

Do you have any children?
☐ No
☐ Yes

If yes, please list the gender and age of each. _____

_____

What do you consider to be your closest relationships or primary source of social/emotional support?

_____

Physical Health History

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: _____

_____

Please list any medications, herbs, or supplements you are currently taking, including any psychiatric medications. _____

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very good Excellent

How would you rate your current eating habits?

Poor Unsatisfactory Satisfactory Good Very good Excellent

Please briefly describe your diet and exercise habits, and how you view your weight and body image.

_____

Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe briefly, including how you are managing it. _____

_____

Additional Information

If you work or are in school, briefly describe your experience, i.e., quality of your performance, what you like and dislike, etc. _____

_____

What do you enjoy doing in your free time? What do you do to relax? _____

_____

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

If yes, please briefly describe your faith or belief: _____

_____

What do you see as your greatest personal strengths and achievements? _____

_____

What do you consider to be some of your weaknesses? _____

_____

If you were living your ideal life, what about your current life would be different?

_____

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

_____