

**INTAKE FORM**

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

**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**

1. Referred by:  
 Medical Provider: \_\_\_\_\_

- Website ([www.drerinjoyce.com](http://www.drerinjoyce.com))
- Psychology Today website
- Friend/Family: \_\_\_\_\_
- Other: \_\_\_\_\_

2. Briefly, what brings you in to therapy now? \_\_\_\_\_  
 \_\_\_\_\_

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

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

4. What areas of your life have been affected because of this problem? \_\_\_\_\_  
 \_\_\_\_\_

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

6. If yes to q. 5, please check all that apply:
- Psychotherapy
  - Psychiatric Medication
  - Outpatient hospitalization or day treatment program
  - Inpatient hospitalization

a) Please briefly explain the reason for receiving the above previous mental health treatment.  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Are you currently experiencing overwhelming sadness, grief, or depression?  No     Yes

a) If yes, for approximately how long? \_\_\_\_\_

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

8. Do you have a history of suicidal thoughts or any suicide attempts?  No     Yes

If yes, please explain. \_\_\_\_\_

9. Do you have a history of engaging in any self-harm behaviors, e.g., cutting?  No  Yes  
If yes, please explain. \_\_\_\_\_
10. Are you currently experiencing anxiety, panic attacks, or any phobias?  No  Yes  
If yes, please explain. \_\_\_\_\_
11. Have you experienced any abuse or traumatic events at any point in your life?  No  Yes  
If yes, please describe briefly if you feel comfortable doing so. \_\_\_\_\_  
\_\_\_\_\_
12. Have you experienced any significant losses at any point in your life?  No  Yes  
If yes, please explain briefly. \_\_\_\_\_  
\_\_\_\_\_
13. Please describe *current* use of alcohol, tobacco, and/or recreational drugs: \_\_\_\_\_  
\_\_\_\_\_
14. Please describe any *past* use of alcohol, tobacco, and/or recreational drugs: \_\_\_\_\_  
\_\_\_\_\_
15. Do you have a history of any physical violence or assault towards others?  No  Yes
16. 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
17. Have you experienced any significant life changes or stressful events recently? \_\_\_\_\_  
\_\_\_\_\_
18. What are the main ways you cope with stress? \_\_\_\_\_  
\_\_\_\_\_

### **Family & Relationship History**

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

- 
20. Any family history of mental illness?  No  Yes
21. Any family history of suicide?  No  Yes
22. Sexual Orientation:  
 Heterosexual  
 Gay/Lesbian  
 Bisexual  
 Other: \_\_\_\_\_
23. Relationship Status (Please check all that apply.):  
 Single  
 In a relationship  
 Married  
 Domestic Partner  
 Separated  
 Divorced  
 Widowed
24. If applicable, on a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_
25. Do you have any children?  No  Yes  
If yes, please list the gender and age of each. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
26. What do you consider to be your closest relationships or primary source of social/emotional support? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Physical Health History**

27. How would you rate your current physical health? (Please circle.)  
Poor      Unsatisfactory      Satisfactory      Good      Very good
28. Please list any specific health problems you are currently experiencing: \_\_\_\_\_
29. Please list any medications, herbs, or supplements you are currently taking, including any psychiatric medication. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 
-

30. How would you rate your current sleeping habits?

Poor      Unsatisfactory      Satisfactory      Good      Very good      Excellent

31. How would you rate your current eating habits?

Poor      Unsatisfactory      Satisfactory      Good      Very good      Excellent

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

33. Are you currently experiencing any chronic pain?  No     Yes

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

**Additional Information**

34. Are you employed or in school?  No     Yes

If yes, briefly describe your experience, i.e., quality of your performance, what you like and dislike, etc. \_\_\_\_\_  
\_\_\_\_\_

35. What do you enjoy doing in your free time? What do you do to relax? \_\_\_\_\_  
\_\_\_\_\_

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

If yes, please describe briefly: \_\_\_\_\_  
\_\_\_\_\_

37. What do you see as your greatest personal strengths and achievements? \_\_\_\_\_  
\_\_\_\_\_

38. What do you consider to be some of your weaknesses? \_\_\_\_\_  
\_\_\_\_\_

39. If you were living your ideal life, what about your current life would be different? \_\_\_\_\_  
\_\_\_\_\_

40. What would you like to accomplish out of your time in therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_