INTAKE FORM

Today's Date: _____/_____/_____

Personal Information

Name:			Age:	Sex:
Date of Birth: / /	Marital Status:		Home Phone #: ( ) -	
Address:			Work Phone #: ( ) -	
City:	State:	Zip:	Cell Phone #: ( ) -	
# of Children:	Their Ages:		Message Phone #: ( ) -	
Nearest Relative Living Separately:			Their Phone #: ( ) -	
Partner's Name:			Their Phone #: ( ) -	

Education / Employment Information

Last grade completed in school:	Are you employed now? _____Yes _____No
Present Occupation:	Company Name:
Main occupation during past 5 years:	

Medical Insurance

Insurance Name:			Phone #: ( ) -
Address:			ID #:
City:	State:	Zip:	Group #:

General Information

How did you hear about us? _____

Problems you want help with: _____

_____

_____

How much have you worked during the past two years?_____

Describe your education (# of years of school, special training, etc.):_____

_____

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, etc.): _____

_____

_____Describe your living situation:_____

_____Did anyone in your family die before you were 18 years old? _____ Yes _____ No

Who? _____ How old were you? _____

Other family deaths? _____

PLEASE FILL OUT ALL THREE PAGES

When were you last examined by a physician? _____ Name_____

Present physician's name _____ Phone number _____

List any major health problems for which you have received treatment:

_____

_____

Do you or your family members currently have or have ever had any of the following: (Please check all that apply)

	SELF	FAMILY
HEART PROBLEMS	_____	_____
CANCER	_____	_____
NERVOUS BREAKDOWN	_____	_____
STROKE	_____	_____
CHRONIC ILLNESS _____	_____	_____
ALCOHOL OR DRUG ABUSE	_____	_____
LEGAL PROBLEMS	_____	_____
LEARNING DISABILITY	_____	_____
DEPRESSION	_____	_____
OTHER _____	_____	_____

List any medications you are now taking (prescription and non-prescription): _____

_____

_____

Have you been abused or assaulted? (Circle One) YES NO DON'T REMEMBER

Did you witness abuse between your parents? YES NO DON'T REMEMBER

Did you witness abuse between parent and child? YES NO DON'T REMEMBER

List everyone currently living in your home, including family and other:

NAME	AGE	BIRTHDATE	RELATIONSHIP	OCCUPATION

Have you ever received psychiatric or psychological help or counseling of any kind before? _____ YES _____ NO

If you have, please explain: _____

_____

PLEASE TURN TO PAGE THREE

Please circle any of the following which concern you:

NERVOUSNESS	DEPRESSION	FEARS	SHYNESS
SEXUAL PROBLEMS	SUICIDAL THOUGHT	SEPARATION	DIVORCE
FINANCES	ANGER	SELF-CONTROL	FRIENDS
SLEEP PROBLEMS	STRESS	WORK/SCHOOL	RELAXATION
HEADACHES	TIREDNESS	LEGAL MATTERS	MEMORY
AMBITION	ENERGY	INSOMNIA	MAKING DECISIONS
LONELINESS	INFERIORITY FEELINGS	CONCENTRATION	EDUCATION
CAREER CHOICES	MARRIAGE/RELATIONSHIPS	HEALTH PROBLEMS	TEMPER
NIGHTMARES	CHILDREN	EATING PROBLEMS	UNHAPPINESS
SEXUAL ABUSE	PHYSICAL ABUSE	BOWEL TROUBLES	BEING A PARENT
MY THOUGHTS	STOMACH PROBLEMS	GAMBLING	BINGE EATING
EATING TOO LITTLE	TOO HEAVY OR THIN		

Please circle any of the following strengths you have:

CONFIDENT	HARD WORKER	ORGANIZED	SYMPATHETIC	GOOD LISTENER
DEPENDABLE	SENSITIVE	LOGICAL	LOYAL	
DECISIVE	RESPONSIBLE	UNDERSTANDING	SENSE OF HUMOR	

OTHER _____

Please use the chart below to describe your use of drugs. Complete the "yes" or "no" lines for each drug listed, and if "yes", answer the remaining questions on the line.

	No, I Never Used	Yes, I Used	If yes, age at first use	When using, frequency of use (daily, weekly, etc.)	How long since last used?
Tobacco					
Alcohol					
Marijuana/Hashish					
Cocaine					
Crack					
Crank					
Amphetamine/Speed					
Hallucinogens (LSD, Mushrooms, Mescaline, etc.)					
Coffee					
Other					

Please add any additional information which you feel may be helpful to us:

_____

_____

THANK YOU FOR FILLING OUT THIS FORM