



Intake Form

Please provide the following information and answer the questions below.

Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Marital Status:
 Never Married Domestic Partnership Married Separated
 Divorced Widowed

Please list any children/age:

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () _____
May we leave a message? Yes No

Cell/Other Phone: () _____
May we leave a message? Yes No

E-mail: _____
May we email you? Yes No
Permission to send C.P.R.G. Monthly Newsletter: Yes No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*



Where did you hear about C.P.R.G. ?: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
- Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

- Yes
- No

Please list: _____

Have you ever been prescribed psychiatric medication?

- Yes
- No

Please list and provide timeframe:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. 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:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in:



4. Please list any difficulties you experience with your appetite or eating patterns.

5. Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

- No
- Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe? _____

8. How often do you drink alcohol? Daily Weekly Monthly Infrequently Never

9. How often do you engage recreational drug use? Daily Weekly Monthly

Infrequently Never

10. Are you currently married, engaged, in a romantic relationship? No Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently? _____



SELF & FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a personal or family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle and List Self or Family Member

Alcohol/Substance Abuse	yes / no	self / family _____
Anxiety	yes / no	self / family _____
Depression	yes / no	self / family _____
Domestic Violence	yes / no	self / family _____
Eating Disorders	yes / no	self / family _____
Obesity	yes / no	self / family _____
Obsessive Compulsive Behavior	yes / no	self / family _____
Schizophrenia	yes / no	self / family _____
Suicide Attempts	yes / no	self / family _____

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

If yes, describe your current employment situation:

Do you enjoy your work? Is there anything stressful about your current work?

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

If yes, describe your faith or belief:



3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

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

Anything else you would like me to know?
