HARBORSIDE COUNSELING

Intake Form

Please fill out the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

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

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

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

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

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

Work Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

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

Emergency Contact: _____
(Name) (Relationship) (Phone Number)

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any other household member(s) with age(s):

_____

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

_____
(Last) (First) (Middle Initial)

Referred by (if any): _____

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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 dates: _____

_____

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. Do you drink alcohol more than once a week?
   □ No □ Yes

9. How often do you engage recreational drug use?
   □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship?
    □ No □ Yes
    If yes, for how long? _____
    On a scale of 1-10, how would you rate your relationship? _____

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

    _____

    _____

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FAMILY MENTAL HEALTH HISTORY:

In the section below 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 provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

   If yes, what is 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 weakness?

   _____

   _____

   _____

   _____

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

   _____

   _____

   _____

   _____