A Susan Brenner, LMFT

INTAKE FORM

Name_____

Today's Date_____

Date Of Birth_____ Address_____

City_____ State_____ Zip_____

Marital Status_____ Sex_____

Employer_____

Referred By_____

Home Phone _____

Work _____Cell_____

Email Address _____

Name of Spouse/Significant Other:_____

Phone_____

Primary Health Care Physician_____

Address_____

City_____ State_____ Zip_____

Phone #_____

I give permission to consult with Primary Provider, Psychiatrist, Psychologist, Social Worker

Initial_____Date_____

Release Of Information

I authorize the release of my medical or other information necessary to process this claim

Initial_____Date_____

In Case Of Emergency, Please Notify

Name_____

Phone_____

Relationship_____

Referred by:

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

□No

□Yes, current therapist's name_____

phone_____

Have you had previous psychotherapy?

□No

□Yes, previous therapist's name_____

phone_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

□Yes □No

If no, have you been previously prescribed psychiatric medication?

□Yes □No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits?

□ No □ Yes

If yes, check where applicable:

□ Eating less □ Eating more

□ Binging □ Restricting □ Purging

Have you experienced significant weight change in the last 2 months?

□ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

7. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?

□ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently 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 the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors?

Have you ever experienced the following? and if so when?

Extreme depressed mood yes/no

Wild Mood Swings yes/no

Rapid Speech yes/no

Extreme Anxiety yes/no

Panic Attacks yes/no

Phobias yes/no

Sleep Disturbances yes/no

Hallucinations yes/no Unexplained losses of time yes/no

Unexplained memory lapses yes/no

Alcohol/Substance Abuse yes/no

Frequent Body Complaints yes/no

Eating Disorder yes/no

Body Image Problems yes/no

Repetitive Thoughts (obsessions) yes/no

Repetitive Behaviors (frequent checking) yes/no

Homicidal Thoughts yes/no

Suicide Attempt yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position?

If yes, are you happy at your current position?

Please list any work-related stressors, if any:

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family of origin experienced difficulties with the following? (circle any that apply and **specify which family member, e.g. Parent, Sibling, Grandparent**

Depression yes/no

Bipolar Disorder yes/no

Anxiety Disorders yes/no

Panic Attacks yes/no

Schizophrenia yes/no

Alcohol/Substance Abuse yes/no

Eating Disorders yes/no

Learning Disabilities yes/no

Trauma History yes/no

Suicide Attempts yes/no

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?