Essential Connections Therapy
Intake Form

Welcome to Essential Connections Therapy! I look forward to our first meeting. Please provide the following information. Although I request contact info, no one will be contacted without a separate release from you. **Please note:** This document is protected as confidential. Please bring this to your first session.

Name: _____ Date: _____

Birth Date: _____/_____/_____ Age: _____Gender: _____

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

Referred by: _____

Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

What is the configuration of your household? _____

Please list any children/ages/custody: _____

_____

Your Address: _____

_____(City) _____(State) _____(Zip)

Work Name and Address: _____

Home Phone: (___)_____Cell Phone: (___)_____ Work Phone: (___)_____

May I leave a message? Home- □ Yes □ No Cell- □ Yes □ No Work-□ Yes □ No

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

*Please note: Email correspondence is not considered to be a confidential medium of communication. My emails (when sent from hushmail) to you, however, are encrypted and therefore confidential.

If applicable:
Insurance Company: _____Insurance Phone #: _____

Insurance Card #: _____Group #:_____

In whose name is the insurance, their DOB and their relationship to you?
_____

Do you give me permission to submit your insurance forms for you?
□ Yes □ No Please sign and print your name below if you give me that permission.

_____

Whom shall I contact in case of an emergency? _____

What is their phone info? _____Their relationship to you? _____

Do you give me permission to contact them in an emergency and share the context of that emergency?
□ Yes □ No Please sign and print your name below if you give me that permission.

_____

Initials_____

HEALTH

1. How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good □ Fantastic

Please list any specific health problems you are currently experiencing:

_____

Are you currently taking prescription medication? □ Yes □ No Please list meds and condition:

_____

Please list your doctor's name and phone number: _____

Do you have any injuries, conditions, serious illnesses about which I need to be aware?

_____

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

□ No □ Yes, previous therapist/practitioner and contact info (won't contact unless you sign a release):

_____

3. Have you ever tried to harm yourself? □ Yes □ No If so, when and how _____

_____

_____

4. Have you ever gone to the ER or been inpatient for mental health issues?

□ No □ Yes when and where: _____

5. Have you ever been prescribed psychiatric medication? □ Yes □ No Please list meds and diagnosis.

_____

_____

Are you on them now? □ Yes □ No Are/Were they helpful: □ Yes □ No □ Yes □ No □ Yes □ No

6. How is your eating? Has it changed recently?

_____

_____

7. How is your sleeping? Has it changed recently?

_____

_____

8. Do you exercise? If so, what do you do, how frequently and for how long?

_____

_____

9. If you use drugs that haven't been prescribed, please share what and frequency.

_____

10. If you drink alcohol, please share how much and frequency.

_____

11. Do you smoke cigarettes and if so what amt per day? _____

12. Do you drink sodas, coffee, tea with caffeine? How much and frequency?_____

13. Please check for family (state which relative) is and self: _____Check here if adopted

Family(whom) Self

_____Alcohol/substance abuse
_____Anxiety
_____Depression
_____Domestic Violence
_____Eating disorder
_____Obesity
_____Obsessive Compulsive Behavior
_____Bipolar disorder
_____Schizophrenia
_____Other

Initials_____
If you do not feel comfortable answering any of these questions today, please leave them blank.

OTHER LIFE AREAS
1. Are you currently employed? □ No □ Yes □ Part □ Full If yes, where _____
Do you enjoy work? □ No □ Yes □ Somewhat Is there any specific stressor there?
_____
_____

6. Are you currently in school? □ No □ Yes Where: _____Major:_____
Do you enjoy school? □ No □ Yes □ Somewhat Is there any area that is particularly stressful?
_____
_____

7. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:
_____
_____

8. 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? _____ Please explain: _____
_____
_____
If not, are you in the midst of a break up, separation, or divorce? □ No □ Yes If yes, for how long? _____

9. Briefly describe how you feel about your sexual self (libido etc.)?
_____
_____
_____
_____

10. Have you experienced any trauma in your life (deaths, accidents, witness a crime, domestic violence, sexual abuse…)? □ No □ Yes (If yes and you feel comfortable underline which category)

THERAPY GOALS
1. What do you consider to be some of your strengths and skills?
_____
_____
_____
_____

2. What are some of your hobbies/interests?
_____
_____
_____

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

3. Have you experienced any significant life changes or stressful events recently: □ No □ Yes. Briefly explain:
_____
_____
_____
_____

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

Initials_____

_____

5. Have you tried to change this issue before? If so, how?

_____
_____
_____
_____

6. Why are you seeking help at **this** particular time?

_____
_____
_____
_____

7. How will you know the issue you are working on is solved? What would your life look like?

_____
_____
_____
_____

QUESTIONS FOR ME?

_____
_____
_____
_____
_____
_____