

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: __

Marital Status:

Never Married Seriously Dating 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

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

Referred by (if any):



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

No

Yes

If yes, for approximately how long? __

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

No

Yes

If yes, when did you begin experiencing this? __

4. Are you currently experiencing any chronic pain?

No

Yes

If yes, please describe __

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

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

7. What significant life changes or stressful events have you experienced recently:

8. Are you currently employed? No Yes

If yes, what is your current employment situation:



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

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.).

		List Family Member
yes/no	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	Shizophrenia	
yes/no	Suicide Attempts	