Jill R. Stevens, MA, LCPC

INTAKE INFORMATION

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

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

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

Referred by (if any): _____

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

□ No
□ Yes, previous therapist/practitioner: _____
□ Approximate dates: _____

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 as possible (if you need more space, please provide separate list or use back of sheet: _____

_____

_____

_____

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 experienced recently:

_____
_____
_____
_____
_____
_____
_____

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(s)
Alcohol/Substance Abuse	yes	no	
Anxiety	yes	no	
Depression	yes	no	
Domestic Violence	yes	no	
Eating Disorders	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?

_____

_____

_____

_____

_____

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