



PSYCHOTHERAPY INTAKE FORM

Contact Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Preferred phone number (indicate cell/home/other): \_\_\_\_\_

Alternate phone number (indicate cell/home/other): \_\_\_\_\_

E-mail: \_\_\_\_\_

May we leave a message at the above phone numbers?: \_\_\_\_\_

May we contact you via email?: \_\_\_\_\_

\*Please remember that we cannot guarantee the confidentiality of email correspondence

How would you like to be reminded of upcoming appointments? Please indicate phone, text, e-mail, or none: \_\_\_\_\_

\*Appointment reminders are generated from our EHR and will be sent from 650-267-2487 and appointmentreminders@therapyportal.com

Who referred you to this clinic: \_\_\_\_\_

Emergency contact (name/phone number/relationship): \_\_\_\_\_

Reason(s) for Seeking Therapy

What 2-3 things do you hope to accomplish through our work together? That is, what would you like to be doing differently by the time our work is finished? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical and Emotional Health History

Who is your primary care provider?: \_\_\_\_\_

Clinic name/address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

What are your current and past health conditions?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide a list of your medications and supplements, if none, initial here: \_\_\_\_\_

On a scale of 0-10 (0=no pain, 10=worst imaginable pain) please answer the following questions:

How would you rate your physical pain RIGHT NOW?: \_\_\_\_\_

Over the past week, how would you rate your USUAL level of pain?: \_\_\_\_\_

Over the past week, how would you rate your BEST level of pain?: \_\_\_\_\_

Over the past week, how would you rate your WORST level of pain?: \_\_\_\_\_

Have you ever been diagnosed with a psychiatric, mental health, or emotional condition, including depression and anxiety? If yes, please list which conditions: \_\_\_\_\_

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Have you ever received psychological, drug or alcohol treatment, or counseling services? If yes, please indicate which type of treatment and whether inpatient or outpatient: \_\_\_\_\_

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Do you now, or have you ever, taken medication for a psychiatric, mental health, or emotional condition, including depression and anxiety? If yes, please list your prescribing health care provider: \_\_\_\_\_

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How often do you consume a drink containing alcohol, including beer and wine?: \_\_\_\_\_

Do you currently use tobacco products?: \_\_\_\_\_

Do you currently use any type of recreational drugs, including marijuana?: \_\_\_\_\_

## **Personal Background/Family History**

Racial/Ethnic Background?: \_\_\_\_\_

Gender Identity: \_\_\_\_\_

What, if any, spiritual, or religious traditions do you follow?: \_\_\_\_\_

Where were you born?: \_\_\_\_\_

Where did you grow up?: \_\_\_\_\_

What is your current living situation? \_\_\_\_\_

Are you currently experiencing any violence or abuse in your home?: \_\_\_\_\_

Current relationship status: \_\_\_\_\_

If applicable, please answer the following:

What is your spouse/partner's name?: \_\_\_\_\_

Please list child(ren)'s name(s) and age(s): \_\_\_\_\_

Number of grandchildren?: \_\_\_\_\_ Great-grandchildren?: \_\_\_\_\_

To the best of your knowledge, has a blood relative suffered from any of the following?:

Bi-Polar (manic-depressive) Disorder?: \_\_\_\_\_ Schizophrenia?: \_\_\_\_\_

Obsessive Compulsive Disorder?: \_\_\_\_\_ Alcoholism?: \_\_\_\_\_

Dementia/Alzheimer's?: \_\_\_\_\_ Attention Deficit Disorder?: \_\_\_\_\_

Drug Abuse?: \_\_\_\_\_ Suicide Attempt?: \_\_\_\_\_

Significant people/organizations in your life (e.g., family members, friends, communities): \_\_\_\_\_

Do you have any legal history (e.g., DUI, incarceration, litigation)?: \_\_\_\_\_

## Occupational/Educational Background

Are you currently working?: \_\_\_\_\_ If no, when did you last work?: \_\_\_\_\_

Current or primary lifetime occupation?: \_\_\_\_\_

Years of education?: \_\_\_\_\_

Military service branch?: \_\_\_\_\_ Year Enlisted?: \_\_\_\_\_

Year Discharged?: \_\_\_\_\_ Honorable discharge?: \_\_\_\_\_

## Other

Is there anything you wanted to add or did not have room for above? Please add below:

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