

## Main Line Adult Counseling

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Paoli, Pennsylvania 19301

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### Intake Form

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

Medical Provider:

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Insurance Provider:

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Website at [www.mainlineadultcounseling.com](http://www.mainlineadultcounseling.com)

Psychology Today website

Friend/Family:

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Have you previously received any type of mental health services?     No         Yes

If yes, which of the following:

psychotherapy    medication    outpatient hospitalizations    inpatient hospitalization

Please provide:

Name of provider or facility:

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Location:

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Dates of treatment:

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Reason for treatment:

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Briefly, what brings you in today?

When did your problem first start? Within the last:

30 days  6-12 months  2 years  During adolescence  During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

No  
 Yes

If yes, for approximately how long? \_\_\_\_\_

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

No  
 Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

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

### **Family History**

Where were you born?

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Where did you grow up?

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city       suburbs       country

Please list your parents and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they now live?	If deceased, age and cause of death

Who did you live with, growing up?

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Mother's occupation:

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Father's occupation:

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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.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	

Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:

- Never Married  
 Domestic Partner     Married

For how long? \_\_\_\_\_

Please give partners name: \_\_\_\_\_

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_

- Separated     Divorced     Widowed

If widowed, please give partners name, and year deceased:

\_\_\_\_\_

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 list any children, their names, and ages:

Name	Age	Name of other parent	If deceased, age and cause of death

**Physical Health**

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

Prescribing provider and contact information:

Name:

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Specialty:

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Facility:

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Phone, email, or Fax:

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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:

How would you rate your current sleeping habits? (please circle)

Poor      Unsatisfactory      Satisfactory      Good      Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep:    staying asleep    awakening early    sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in?

Please list any difficulties you experience with your appetite or eating patterns:

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Any change in weight over the past year?  No  Yes:

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Are you currently experiencing any chronic pain?  No  Yes

If yes, please describe

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Please describe current use of alcohol, cigarettes, and/or recreational drugs:

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Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

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### **Additional Information**

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious?  No  Yes

If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?