

NAJ Counseling, LLC

303-337-8558  
natalie@najcounseling.com

INTAKE FORM

Please fill out this form and bring to your first session. Note: the information you provide here is protected as confidential information.

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Name of parent/guardian (if under 18 years):  
\_\_\_\_\_  
(Last) (First) (Middle)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

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

Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Other Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Email: May we email you?  Yes  No

Email \_\_\_\_\_

\*Please note: Email correspondence is not considered to be confidential communication.

Referred by: \_\_\_\_\_

Marital Status (circle one)

- |               |                      |         |
|---------------|----------------------|---------|
| Never Married | Domestic Partnership | Married |
| Separated     | Divorced             | Widowed |

List any children/age(s): \_\_\_\_\_

Are you currently employed?

- No
- Yes What is your current employment situation? \_\_\_\_\_

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

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

Do you consider yourself to be spiritual or religious?

- No
- Yes Describe your faith or belief system: \_\_\_\_\_

## GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

- No
- Yes Previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication?

- No
- Yes Please list: \_\_\_\_\_

Have you ever been prescribed psychiatric medication?

- No
- Yes Please list and provide dates: \_\_\_\_\_

Are you currently taking vitamins and/or supplements?

- No
- Yes Please list: \_\_\_\_\_

How would you rate your current physical health? (circle one)

Poor      Unsatisfactory      Satisfactory      Good      Very Good      Excellent

List any specific health problems you are currently experiencing:

\_\_\_\_\_

How would you rate your current sleeping habits?

Poor      Unsatisfactory      Satisfactory      Good      Very Good      Excellent

List any specific sleep problems you are currently experiencing:

\_\_\_\_\_

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

What types of exercise do you participate in? \_\_\_\_\_

\_\_\_\_\_

List any difficulties you experience with your appetite or eating patterns:

\_\_\_\_\_

Are you currently experiencing any chronic pain?

- No
- Yes Describe: \_\_\_\_\_

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

- No
- Yes For approximately how long? \_\_\_\_\_

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

No

Yes Describe: \_\_\_\_\_

Do you drink alcohol more than once a week?

No

Yes Describe: \_\_\_\_\_

How often do you engage recreational drug use? (circle one)

Daily      Weekly      Monthly      Rarely      Never

Are you currently in a romantic relationship?

No

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

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

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

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

What would you like to accomplish in therapy?

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

What do you consider to be some of your strengths? \_\_\_\_\_

\_\_\_\_\_

What do you consider to be some of your weaknesses? \_\_\_\_\_

\_\_\_\_\_

## FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If you answer yes to any of the following items, please indicate the family member's relationship.

Alcohol/Substance Abuse	Circle One Yes / No
Anxiety	Yes / No
Depression	Yes / No
Domestic Violence	Yes / No
Eating Disorders	Yes / No
Obesity	Yes / No
Obsessive Compulsive Disorder	Yes / No
Schizophrenia	Yes / No
Suicide Attempts	Yes / No