NAJ Counseling, LLC

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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.

	Circle One
Alcohol/Substance Abuse	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