INTAKE FORM

Date	Last Name	First Name
Address		
City	State	Zip
Email Address		
*Home Phone	Cell Phone	Work Phone
Preferred gender		DOB
Is it acceptable to contact you at home? **Y / N**	If "no" then how can I contact you?	
Are you currently under medical care? **Y / N**	If “yes” then please explain/describe.	
Name of Personal Physician		Phone Number
Are you currently taking prescribed medications? **Y / N**	List any psychiatric/mental health medications you have taken.	
Have you been under the care of a psychiatrist, psychologist, or counselor? **Y / N**	If “yes” please give the name, date, and location of the therapy and briefly explain the nature of the problem that required attention.	

Please circle any of the following struggles that pertain to you:

Anxiety	Depression	Fears/Phobias	Eating Disorders
Sexual Problems	Suicidal Thoughts	Separation/Divorce	Relationships
Finances	Drug/Alcohol Use	Career Choices	Anger
Self-Control	Unhappiness	Insomnia	Religious Matters
Work/Stress	Health Problems	Cutting/Self-harm	Thought Patterns