Initial Intake Form

Name _____ **Age**_____ **Birth date** _____

Address _____ **Email** _____

City _____ **State**_____ **Zip** _____

Home Phone _____**Work Phone** _____**Cell Phone:**_____

Occupation _____ **Employer** _____

Marital Status _____ **Name of Spouse/Partner** _____

How Long Have Both of You Been Together? _____ **Religion** _____

If Client is a Minor, Name of Responsible Adult _____

Do You Smoke?_____**How Much?**_____**Do You Drink?**_____ **How Much?** _____

Do You Take Drugs?_____**If yes, what kind?** _____**How often?**___

Last Medical Examination_____**Reason** _____

Are You Now Under a Doctor's Care?_____**If yes, Doctor's name:** _____

Reason for Doctor's Care: _____

Are You Taking Any Medication?_____**If yes, what kind?** _____

Reason for Medication: _____

Have You Ever Been Hospitalized for a Physical Illness? **Describe:**_____

_____

Have you ever been hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe: _____

_____

Any Previous Therapy/Counseling? _____**If Yes, Name and Phone Numbers of Therapists:**

_____

_____

When and Number of Sessions: _____

Type of Therapy/Counseling: _____

How referred to Dr. Gray: _____

What do you Wish to Achieve with Therapy? _____

_____

_____

_____

_____

Check Any of the Following That May Apply to You:

☐	Headache	☐	Inferiority Feelings	☐	Shy With People
☐	Dizziness	☐	Feel Tense	☐	Can't Make Friends
☐	Fainting Spells	☐	Feel Panicky	☐	Afraid Of People
☐	No Appetite	☐	Fears and Phobias	☐	Home Conditions Bad
☐	Over-Eating	☐	Obsessions	☐	Unable To Have A Good Time
☐	Stomach Trouble	☐	Depressed	☐	Always Worried About Something
☐	Bowel Disturbances	☐	Suicidal Ideas	☐	Don't Like Weekends/Vacations
☐	Always Tired	☐	Take Tranquilizers	☐	Can't Make Decisions
☐	Always Sleepy	☐	Alcoholism	☐	Over-Ambitious
☐	Unable To Relax	☐	Dangerous Drugs	☐	Financial Problems
☐	Insomnia	☐	Anger	☐	Gambling
☐	Recurrent Dreams	☐	Asthma	☐	Job Problems
☐	Nightmares	☐	Homosexuality	☐	Can't Keep A Job
☐	Hallucinations	☐	Sexual Problems	☐	Other _____