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Intake Form

- Please provide the following information and answer the questions below
- Information you provide here is protected as confidential information
- Please fill out this form and bring it to your first session or email to davidknylund@gmail.com

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ / _____ / _____ Age: _____ Gender: _____

Marital Status: ☐ Never Married ☐ Separated ☐ Domestic Partnership
☐ Married ☐ Divorced ☐ Widowed

Please list any children / age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: ( ) _____ May we leave a message? ☐ Yes ☐ No

*Email: _____ May we email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication

Referred by (if any): _____

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

☐ No
☐ Yes, previous therapist / practitioner: _____

Are you currently taking any prescription medication?

☐ No
☐ Yes, please list: _____

_____

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Have you ever been subscribed psychiatric medication?

☐ No
☐ Yes, please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any current health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleeping problems you are currently experiencing:

_____

3. How many times a week do you generally exercise? _____

What types of exercise do you participate in?

_____

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

_____

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

☐ No
☐ Yes

If yes, for approximately how long? _____

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

☐ No
☐ Yes

If yes, when did you begin experiencing this? _____

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7. Are you currently experiencing any chronic pain?

☐ No
☐ Yes
If yes, please describe _____

8. Do you drink alcohol more than once a week? ☐ Yes ☐ No

9. How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

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

_____

_____

_____

_____

FAMILY MENTAL HEALTH INFORMATION:

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.).

			List Family Member
Alcohol / Substance Abuse	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Domestic Violence	☐ Yes	☐ No	_____
Eating Disorders	☐ Yes	☐ No	_____
Obesity	☐ Yes	☐ No	_____
Obsessive Compulsive Behavior	☐ Yes	☐ No	_____
Schizophrenia	☐ Yes	☐ No	_____
Suicide Attempts	☐ Yes	☐ No	_____

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ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

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

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

If yes, please describe your faith or belief.

4. What do you consider to be some of your strengths?

5. What do you consider to be some of your weaknesses?

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

7. Is there any additional information you would like to provide?