

INTAKE

Today's date: _____

Name _____ DOB _____ Gender _____ Age _____ Race/Ethnicity _____

Address _____ City _____ State _____

Zip _____ Telephone _____

Email: _____ How did you hear about me? _____

Marital Status single married partnered divorced separated other: _____

Occupation _____ Employer _____ Years of Education _____

Sexual ID: Heterosexual _____ Bisexual _____ Lesbian _____ Gay Male _____ Transgender _____ Comment _____

Pronouns: _____

Describe the problem that brought you here in your own words, what is not working?

Please check all of the behaviors and symptoms that you currently consider problematic:

- | | | |
|--|---|--|
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Suspicion/paranoia |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Overspending |
| <input type="checkbox"/> Problems focusing | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Anxiety/worry | <input type="checkbox"/> Wide mood swings |
| <input type="checkbox"/> Poor memory/confusion | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Seasonal mood changes | <input type="checkbox"/> Fear away from home | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Loss of pleasure/interest | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Problems with pornography | <input type="checkbox"/> Aggression/fights |
| <input type="checkbox"/> Self-harm behaviors | <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Parenting problems |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Low self-worth | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Guilt/shame | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Seeing things | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Sweating | <input type="checkbox"/> |
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Heart racing | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____ | | |

