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PSYCHOTHERAPY SELF ASSESSMENT INTAKE FORM

The information in this self-assessment will be helpful in the evaluation process.
All material contained in this questionnaire will remain confidential.
I know it's long, but it will save us time and help me with your treatment, if you complete it.
That means you will feel better faster. Hang in there!

1. When you complete this form, please:
   (1) answer all questions that apply as fully as possible; skip any questions that don't apply.
   (2) be as specific as possible in regard to names, dates, ages, etc.
   (3) write on the back side of the paper, if you need more space
   (4) be sure to complete this first page of demographic information and the symptom checklist on page two.

NAME: _____ **DATE:** _____

ADDRESS: _____

TELEPHONE: (Home): _____ **(Cell):** _____

DATE OF BIRTH: _____ **AGE:** _____

REFERRED BY: _____

EMERGENCY CONTACT: _____ **Relationship:** _____

Phone Number (Home): _____ (Cell): _____

What are your current living arrangements (check one)?

☒ Single ☐Family Home ☐ Multi-Family Home ☐ Apartment ☐ Dorm ☐ Other:

Number of Person's Living in Your Household: (including you):

Please List Below:

Name:	***Relationship:***	***Age:***

Please list your main reason(s) for seeking help: _____

How long has this problem(s) existed? _____

Has anything happened recently that made things worse? _____

SYMPTOM CHECKLIST

(Please CHECK any symptoms that are a concern):

☐ Depressed	☐ Low Energy/Exhaustion	☐ Temper Outbursts
☐ Headaches	☐ Hallucinating	☐ Hands Shake
☐ Feel Inferior	☐ Lonely	☐ Hearing Difficulty
☐ Trouble Breathing	☐ Angry	☐ Feeling Tense
☐ Early Morning Awakening	☐ Overambitious	☐ Difficulty Communicating
☐ Dizziness	☐ Sleeping Too Much	☐ Relationship Problems
☐ Bowel Disturbances Fainting	☐ Can't Keep Job Legal	☐ History of Abuse
☐ Menstrual Problems	☐ Family Conflict	☐ Bullied
☐ Issues W/Sexual Function	☐ Financial Struggles	☐ Cutting or Self-Harm Loss
☐ Issues W/Sexual Drive Compulsion or Addiction	☐ Weight Gain / Over-Eating	☐ Trouble with Authority
☐ Can't Make Decisions	☐ Lack of Appetite	☐ Confusion or Memory
☐ Feeling Hopeless	☐ Weight Loss / Not Eating	☐ Major Life Change/Stressor
☐ Unusual Feelings	☐ Excessive Gambling	☐ Trouble with Authority
☐ Can't Concentrate	☐ Drug Use	☐ Social Isolation
☐ Numbness or Tingling	☐ Can't Relax	☐ Shyness/Social Anxiety
☐ Fast Heartbeat	☐ Feel Panicky	☐ Domestic Violence
☐ Can't Sleep	☐ Excessive Drinking	☐ Other:
☐ Hearing Voices	☐ Nausea/Vomiting	☐ Other:
☐ Racing Thoughts	☐ Nervous	☐ Other:

Please list the symptoms you feel that you need the most help with at this time:

_____

Do you feel suicidal and/or do you have a history of suicidal thoughts? _____

If yes, do you have a plan? ☐ YES or ☐ NO

Plan: _____

Do you feel like injuring someone else? ☐YES or ☐ NO

If yes, do you have a plan? ☐YES or ☐ NO

Plan: _____

MEDICAL HISTORY GENERAL:

Rate your physical health:

☐ Excellent ☐ Good ☐ Average ☐ Declining ☐ Poor

Do you have any concerns about your physical health? _____

Who is your Primary Care Provider?

Phone: _____ Date of last physical check-up: _____

Do you see a psychiatrist? ☐ Yes or ☐ No

If yes, does this psychiatrist know you are seeking therapy? ☐ Yes or ☐ No

Name of Psychiatrist: _____ Psychiatrist's Phone: _____

If you are seeing a psychiatrist, please describe your reason for seeing a psychiatrist and any diagnosis:

_____

Please list any other doctors or providers you are seeing, any medical conditions you are getting treatment for. Please include any homeopathic or alternative treatments as well:

Doctor's Name:	***Medical Condition:***	***Treatment:***

Are you currently taking any medication including psychiatric medication? ☐ Yes or ☐ No

Please list & include any additional herbs, vitamins, and over-the-counter medications

Medication:	***Prescribing Physician:***	***Reason:***

Do you have any allergies? ☐ Yes or ☐ No

If yes, please explain: _____

List all serious operations, injuries and hospitalizations you have experienced: _____

List all serious diseases or illness you had as a child, teenager, or adult: _____

Have you had any of these medical problems? (check the ones that apply)

☐ Seizures or Epilepsy	☐ Chronic Pain	☐ Hypertension
☐ Thyroid Problems	☐ Reproductive Problems	☐ Hypotension
☐ Heart problems	☐ Allergies to Medications	☐ Skin Condition
☐ Fibromyalgia	☐ Glaucoma	☐ Arthritis
☐ Hepatitis	☐ Urinary Problems	☐ Cancer
☐ Asthma	☐ Digestive Problems	☐ Other (Please specify):
☐ Anemia	☐ Diabetes	☐ Other (Please specify):

Please describe your level of physical activity and daily amount of exercise: _____

Do you have any Body Image Concerns? Explain: _____

MEDICAL HISTORY (WOMEN):

Do you ever experience any menstrual pain or irregularity? _____

Do periods affect your mood? ☐ Yes or ☐ No

Please explain: _____

Have there been any complications during or following your pregnancies? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had any infertility, abortions, miscarriages, or stillbirths? ☐ Yes ☐ No

If yes, please explain: _____

Have you undergone or are you about to undergo menopause ☐ Yes ☐ No

If yes, how has it affected you? _____

CHILDHOOD AND FAMILY HISTORY:

Briefly describe your home life when you were growing up: _____

Were you raised by your birth parents? ☐ Yes ☐ No

Are your parents: ☐ separated ☐ divorced ☐ never married

Are you parents still living? Father: ☐ Yes ☐ No Mother: ☐ Yes ☐ No

If parents are living, are your parents living together? ☐ Yes ☐ No

Describe your parent's marriage: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

As a child did you feel closest to your (CHECK one): ☐ Father ☐ Mother ☐ Neither ☐ Another Adult

If another, please describe: _____

Who was the person who had the greatest influence in your life? _____

Rate your childhood life: ☐ Very happy ☐ Happy ☐ Average ☐ Unhappy

How were feelings expressed in your family? _____

How do you think your childhood experiences affect your situation today? _____

In what ways were you punished while growing up? _____

Do you have a history of abuse of any kind? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever lost a member of your family or someone close to you through death? ☐ Yes ☐ No

If so, please give more details: _____

Please, describe any fearful or distressing childhood experiences you have had, or anything noteworthy that was wonderful: _____

Is there anything else I should know about your parents or family of origin? _____

Please list your brothers and sisters in birth order:

First Name:	***Gender/Age:***	***How would you describe your relationship?***

EDUCATIONAL HISTORY:

What was the highest grade you have completed in school? _____

Did you ever have special abilities or difficulties? ☐ Yes ☐ No

If yes, please describe: _____

Did you have any problems in school? ☐ Yes ☐ No

If yes, explain: _____

How would you rate yourself on the following during growing up years?

(Please CHECK the appropriate description for each category)

ATHLETICS	☐Active	☐Average	☐Less than Average	☐None
GRADES	☐Honor Roll	☐Average	☐Below Average	☐Varied
POPULARITY	☐Popular	☐Average	☐Unpopular	☐Loner
DATING	☐Popular	☐Average	☐Unpopular	☐Loner

During your childhood did you tend to be a: ☐leader ☐follower ☐loner

During adolescence did you tend to be a: ☐leader ☐follower ☐loner

OCCUPATIONAL HISTORY:

Are you currently employed? ☐ Yes ☐ No

If married, is your spouse employed? ☐ Yes ☐ No

If yes, please indicate the kind of work you do, the length of time you have held the job and your current position: _____

Yourself: _____

Spouse: _____

If you or your spouse is currently unemployed, how long have you been unemployed?

Yourself: _____

Spouse: _____

MARITAL HISTORY

Marital Status: ☐ single ☐ living together ☐ married ☐ separated ☐ divorced ☐ widowed

How long did you know your spouse before marriage? _____

How old were you when you met your significant other? _____ Married? _____

How long have you been married or were you married? _____

Have you or your current spouse had any previous marriages? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any children in current marriage? ☐ Yes ☐ No Former relationship/marriage? ☐ Yes ☐ No

Names/Ages: _____

Who has custody currently? _____

Are there any issues with regards to co-parenting? ☐ Yes ☐ No Blended families? ☐ Yes ☐ No

Custody? ☐ Yes ☐ No

If yes, please explain: _____

MENTAL HEALTH HISTORY:

Have you received any psychological/psychiatric treatment or counseling before? ☐ Yes ☐ No

If yes, please complete:

Approximate date	***Name of Provider:***	***Focus of Therapy:***	***Was it Helpful?***
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Was there anything you did/didn't like about your experience/s? _____

Have you ever been hospitalized for emotional reasons or substance abuse? ☐ Yes ☐ No

If yes, please explain including approximate dates, length of treatment & reason:

_____

Have you ever thought of harming yourself? ☐ Yes ☐ No

Do you cut or self-mutilate/self-harm? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, please give the date(s) and attempt method(s): _____

Have you had any family members who have committed/attempted suicide? ☐ Yes ☐ No

If yes, give date(s), how, and name relationship: _____

Have any family members (parents, grandparents, sisters/brothers, children, aunts, uncles, cousins) been hospitalized for emotional reasons, had alcohol/drug problems, been diagnosed with mental illness or had severe mood swings?

☐ Yes ☐ No

If yes, please list their relationship to you and what the problem was: _____

SELF ASSESSMENT - Please rate yourself on a scale of 1 to 10:

('10' signifying you excel in, '5' signifying you are average in, and '1' signifying you have great difficulty)

_____ I can deal constructively with reality

_____ I can adapt to change

_____ I am free from symptoms that are produced by tensions and anxieties

_____ I find more satisfaction in giving than receiving

_____ I can relate to other people in a consistent manner with mutual satisfaction

_____ I direct my angry energies into creative and constructive outlets

_____ I have a capacity to love

What do you feel are your greatest strengths? _____

What do you see as your vulnerabilities? _____

What areas of your life do you feel you are successful? _____

Do you have coping skills that you use when you are stressed or upset? ☐ Yes ☐ No

If yes, please describe your strategies and how helpful they are: _____

SUBSTANCE USE

Do you:	drink alcohol?	☐ Never	☐ Occasionally	☐ Daily (# per day)
	smoke cigarettes?	☐ Never	☐ Occasionally	☐ Daily
	smoke marijuana?	☐ Never	☐ Occasionally	☐ Daily
	other drug use?	☐ Never	☐ Occasionally	☐ Daily

Has your drug or alcohol use ever been a problem for you? ☐ Yes ☐ No

Has anyone in your life ever been concerned about your drug or alcohol use? ☐ Yes ☐ No

Can you stop drinking without difficulty after 1 or 2 drinks? ☐ Yes ☐ No

Do you often drink more than you intend? ☐ Yes ☐ No

In what situations are you most likely to drink? _____

Have you had any problems on the job as a result of your substance use such as lateness, absenteeism, arguments or problems with coworkers and bosses, poor productivity, difficulty concentrating, loss of employment, suspension or warnings on the job? ☐ Yes ☐ No

If yes, please describe: _____

When under the influence of a substance, are you more aggressive, engage in dangerous behavior such as driving under the influence, operating equipment or caring for children? ☐ Yes ☐ No

If yes, please describe: _____

Have you had any prior treatment for substance abuse? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever attended A.A., N.A., C.A. or other 12-step programs? ☐ Yes ☐ No

If yes, please describe the circumstances, how often you attend(ed): _____

Is there a history of substance use in your family? ☐ Yes ☐ No

If yes, please indicate which members have been or are affected? _____

WORLD VIEW/PHILOSOPHY/RELIGIOUS/SPIRITUAL HISTORY:

Please briefly describe your spiritual beliefs, life philosophy, political or world view:

_____

Religious/spiritual background of spouse/partner: _____

Do you attend spiritual and/or religious services? _____

If philosophy, politics, religious or philosophical beliefs are a source of conflict in your relationship/s, please explain:

Are your beliefs a source of comfort and/or distress? _____

Is there anything else that you feel would be helpful for me to know at this time?

Your signature: _____

Date: _____

Thank you very much for taking the time to complete this form!

Gina Kramer, MA, LMFT