

# Lisa Knudson Psychotherapy Intake Form

Name: \_\_\_\_\_

(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

\_\_\_\_\_

(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:

Never Married  Partnered  Married  Separated  Divorced  Widowed

Number of Children: \_\_\_\_\_

Local Address: \_\_\_\_\_

(Street and Number)

\_\_\_\_\_

(City) (State) (Zip)

Home Phone: ( ) \_\_\_\_\_ May I leave a message?  Yes  No

Cell/Other Phone: ( ) \_\_\_\_\_ May I leave a message?  Yes  No

E-mail: \_\_\_\_\_ May I email you?  Yes  No

\*Please be aware that email might not be confidential.

Referred by: \_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?  Yes  No

Have you had previous psychotherapy?

No  Yes, at Previous therapist's name \_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes  No If Yes, please list: \_\_\_\_\_

If no, have you been previously prescribed psychiatric medication?

Yes  No If Yes, please list: \_\_\_\_\_

#### HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

\_\_\_\_\_

3. Are you having any problems with your sleep habits?  No  Yes

If yes, check where applicable:

Sleeping too little  Sleeping too much  Poor quality sleep  Disturbing dreams

Other \_\_\_\_\_

4. How many times per week do you exercise? \_\_\_\_\_

Approximately how long each time? \_\_\_\_\_

5. Are you having any difficulty with appetite or eating habits?  No  Yes

If yes, check where applicable:  Eating less  Eating more  Binging  Restricting

Have you experienced significant weight change in the last 2 months?  No  Yes

6. Do you regularly use alcohol?  No  Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? \_\_\_\_\_

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

Daily  Weekly  Monthly  Rarely  Never

8. Have you had suicidal thoughts recently?  Frequently  Sometimes  Rarely  Never

Have you had them in the past?  Frequently  Sometimes  Rarely  Never

9. Are you currently in a romantic relationship?  No  Yes

If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your current relationship? \_\_\_\_\_

10. In the last year, have you experienced any significant life changes or stressors:

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Have you ever experienced:

Extreme depressed mood:  No  Yes

Wild Mood Swings:  No  Yes

Rapid Speech:  No  Yes

Extreme Anxiety:  No  Yes

Panic Attacks:  No  Yes

Phobias:  No  Yes

Sleep Disturbances:  No  Yes

Hallucinations:  No  Yes

Unexplained losses of time:  No  Yes

Unexplained memory lapses:  No  Yes

Alcohol/Substance Abuse:  No  Yes

Frequent Body Complaints:  No  Yes

Eating Disorder:  No  Yes

Body Image Problems:  No  Yes

Repetitive Thoughts (e.g., Obsessions) :  No  Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) :  No  Yes

Homicidal Thoughts:  No  Yes

Suicide Attempt:  No  Yes

OCCUPATIONAL INFORMATION:

Are you currently employed?  No  Yes

If yes, who is your current employer/position?

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If yes, are you happy at your current position?

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Please list any work-related stressors, if any:

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RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious?  No  Yes

If yes, what is your faith?

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If no, do you consider yourself to be spiritual?  No  Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Depression:  No  Yes \_\_\_\_\_

Bipolar Disorder:  No  Yes \_\_\_\_\_

Anxiety Disorders:  No  Yes \_\_\_\_\_

Panic Attacks:  No  Yes \_\_\_\_\_

Schizophrenia:  No  Yes \_\_\_\_\_

Alcohol/Substance Abuse:  No  Yes  
\_\_\_\_\_

Eating Disorders:  No  Yes \_\_\_\_\_

Learning Disabilities:  No  Yes \_\_\_\_\_

Trauma History:  No  Yes \_\_\_\_\_

Suicide Attempts:  No  Yes \_\_\_\_\_

OTHER INFORMATION:

What do you consider to be your strengths?

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What do you like most about yourself?

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What are effective coping strategies that you've learned?

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What are your goals for therapy?

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