

**ANDREW PRICE THERAPY, LLC
INTAKE FORM**

Information provided on this form is protected as confidential information

Welcome to my practice. I appreciate your help answering these questions to the best of your ability. The information you provide here can help therapy be effective more quickly. If any question is unclear, please let me know and we can discuss it together.

Date: _____

Last Name: _____ First Name: _____

Parent/Legal Guardian (if under 18): _____

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ May we send a text message? YES NO

May we leave a voice message? YES NO

Home Phone: _____ May we leave a voice message? YES NO

Email: _____ May we send an email? YES NO

How did you hear about my practice? _____

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we contact? _____

Contact person's relationship to patient: _____

Contact person's phone numbers: Home: _____

Work: _____

Cell: _____

Primary Care Physician: _____

Relationship: SINGLE PARTNERED MARRIED SEPARATED DIVORCED WIDOWED

Are you a parent? YES NO

Occupation: _____ Work Hours (e.g., 9-5): _____

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

Have you been to therapy before?: YES NO If so, when? _____

Have you ever been prescribed psychiatric medication? YES NO

Are you currently seeing a psychiatrist for medication? YES NO

Psychiatrist Name: _____

Please list any medications you are currently taking (including over-the-counter):

_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been hospitalized for mental health issues? _____

If so, when? _____ Where? _____ How long? _____

GENERAL AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (circle one)

POOR FAIR GOOD VERY GOOD EXCELLENT

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (circle one)

POOR FAIR GOOD VERY GOOD EXCELLENT

Please describe any specific sleeping problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise do you participate in?

Please list any difficulties you experience with appetite or eating problems:

Are you currently experiencing overwhelming sadness, grief, or depression? YES NO

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have phobias? YES NO

If yes, when did you begin experiencing them and when do they arise?

Do you have concerns about hurting yourself or suicidal ideation? YES NO

Are you currently experiencing any chronic pain? YES NO

If yes, please describe: _____

Do you drink alcohol more than once a week? YES NO

How often do you engage in recreational drug use?

DAILY WEEKLY MONTHLY INFREQUENTLY NEVER

Do you have concerns about your alcohol/drug use or other habits and behaviors? YES NO

Are you currently in a romantic relationship?: YES NO If yes, for how long? _____

Rate your relationship from 1 - 10 (1 being poor, 10 being exceptional): _____

Please describe your relationship concerns, if any:

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

FAMILY MENTAL HEALTH HISTORY

Indicate if there is a family history of the following. If answering yes, please list the family member's relationship to you in the space provided (e.g., grandmother, uncle).

	Please Circle	List Family Member
Alcohol/Substance Abuse	YES NO	_____
Anxiety	YES NO	_____
Depression	YES NO	_____
Domestic Violence	YES NO	_____
Trauma	YES NO	_____
Eating Disorders	YES NO	_____
Obesity	YES NO	_____
Obsessive / Compulsive	YES NO	_____
Schizophrenia	YES NO	_____
Suicide Attempts	YES NO	_____

ADDITIONAL INFORMATION

(1) Do you consider yourself to be spiritual or religious? YES NO

If yes, describe your faith or belief:

(2) What do you consider to be some of your strengths?

(3) What do you consider to be some of your vulnerabilities?

(4) What would you like to accomplish in therapy?

(5) What else is important that you'd like me to know?

CLIENT SIGNATURE

DATE

CLIENT NAME