Telka • Smith Intake Form

*If you find **any** of the information requested to be too uncomfortable to consider, then please just leave it blank.*

Name_____**Date**_____

Date of Birth _____ **Age** _____ **Primary Care Physician**_____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist:

( ) Depressed mood	( ) Avoidance	( ) Excessive energy
( ) Racing thoughts	( ) Loss of interest	( ) Excessive guilt
( ) Excessive worry	( ) Chronic Stress	( ) Increased irritability
( ) Unable to enjoy activities	( ) Hallucinations	( ) Fatigue
( ) Impulsivity	( ) Concentration/forgetfulness	( ) Crying spells
( ) Anxiety attacks	( ) Decreased need for sleep	( ) Obsessions, compulsions
( ) Sleep pattern disturbance	( ) Suspiciousness	( ) _____
( ) Increase risky behavior	( ) Change in appetite	( ) _____

Past Mental Health History**:** Please describe past treatment, by whom, and nature of treatment:

_____
_____
_____

Please describe your sleep - insomnia, bad dreams… _____
_____

Do you have any current concerns about your physical health? _____
_____

Is there any important personal or family medical history? _____
_____

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Have you recently had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No

Where did you grow up? _____

How many siblings do you have and where are you in the birth order: _____
_____

What was your father's occupation? _____

What was your mother's occupation? _____

During your childhood, did you experience:

( ) Physical abuse ( ) Sexual abuse ( ) Emotional Abuse
( ) Emotional neglect ( ) Physical neglect ( ) Exposure to domestic violence
( ) Household substance abuse ( ) Household mental illness
( ) Parental separation or divorce ( ) Incarcerated household member

Describe your father and your relationship with him:_____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____

Has anyone in your immediate family died? _____

Trauma History: Have you suffered any overwhelming and traumatic experiences in your life? ( ) Yes ( ) No.
Please describe: _____
_____

Occupational History: Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

What is/was your occupation? _____

Marital Status: Are you currently ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed

How would you identify your orientation? ( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual ( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____
_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender:
_____
_____

Describe your relationship with your children: _____

_____

Legal History: Have you ever been arrested? _____

Do you have any pending legal problems? _____

Is there anything else that you would like us to know?

_____
_____
_____
_____