STATERA
Integrated Health & Wellness Solutions

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Adult Psychotherapy Intake Form

Full Name _____ Today's Date_____

Male_____ Female_____ Date of Birth_____ Age_____

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Is it OK to contact you at home? _____OK to leave a message? _____

Mobile Telephone _____ Is it OK to contact this number? _____OK to leave a message? _____

How did you learn about the psychotherapy services provided at this office: _____
_____

REASON FOR SEEKING TREATMENT:
Please briefly describe the problems you are experiencing.
_____
_____
_____
_____

Name of Current Psychiatrist (and phone #): _____

Have you ever had previous therapy/counseling of any kind? □ yes □ no If yes, when, with whom, and for how long?
_____
_____

Have you ever been hospitalized for emotional problems? □ yes □ no Or for substance abuse problems? □ yes □ no
If yes to either of the above, please note when, where, and for how long were you hospitalized? _____
_____
_____

Please check all of the items below that describe your situation:

□ Abuse/trauma – physical, sexual, emotional, neglect
□ Aggression, violence
□ Alcohol use
□ Anger, hostility, arguing, irritability
□ Anxiety, nervousness
□ Attention, concentration, distractibility
□ Career concerns, goals, and choices
□ Childhood issues
□ Codependence
□ Confusion
□ Compulsions and/or obsessions (thoughts or actions that repeat themselves)
□ Decision-making, indecision, mixed feelings, putting off decisions
□ Delusions (false ideas)
□ Dependence
□ Depression, low mood, sadness, crying
□ Divorce, separation, marital conflict, infidelity/affairs
□ Drug use – prescription medications, over-the-counter medications, street drugs
□ Eating problems – overeating, undereating, appetite, vomiting
□ Emptiness
□ Failure
□ Fatigue, tiredness, low energy
□ Fears, phobias
□ Financial or money troubles, debt, impulsive spending, low income
□ Gambling
□ Grieving, mourning, deaths, losses, divorce
□ Guilt
□ Headaches, other kinds of pains
□ Health, illness, medical concerns, physical problems
□ Inferiority feelings
□ Impulsiveness, loss of control, outbursts
□ Irresponsibility
□ Judgment problems, risk taking
□ Legal matters, charges, suits
□ Loneliness
□ Memory problems
□ Mood swings
□ Oversensitivity to rejection
□ Panic or anxiety attacks
□ Perfectionism
□ Pessimism
□ Procrastination, lack of motivation
□ Relationships problems (with friends, with relatives, or at work)
□ School problems
□ Self-centeredness
□ Self-esteem
□ Self-neglect, poor self-care
□ Sexual issues, dysfunctions, conflicts, identity issues
□ Sleep problems (too much, too little, insomnia, nightmares)
□ Spiritual, religious, moral, ethical issues
□ Stress and tension
□ Suspiciousness
□ Suicidal thoughts
□ Temper problems, self-control, low frustration tolerance
□ Thought disorganization and confusion
□ Threats, violence
□ Weight and diet issues
□ Withdrawal, isolation
□ Work problems, employment issues

SUBSTANCE USE HISTORY:

Have you ever experienced a problem with alcohol, drugs, or prescription medications? ☐ yes ☐ no

If yes, please explain: _____

_____

_____

_____

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications? ☐ yes ☐ no

If yes, please explain: _____

_____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs? ☐ yes ☐ no If, yes, please explain: _____

_____

Have you had any problems related to use of alcohol/drugs in the past year? ☐ yes ☐ no

If, yes, please explain: _____

_____

_____

Has drinking or drug use ever caused you problems in the following areas (check if yes):

☐ family ☐ school ☐ employment ☐ legal ☐ emotional ☐ social ☐ financial ☐ behavior ☐ physical health

FAMILY BACKGROUND:

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN: ☐

Names of Children	Living with you?	Age	Grade	School
1. _____	☐ yes ☐ no	_____	_____	_____
2. _____	☐ yes ☐ no	_____	_____	_____
3. _____	☐ yes ☐ no	_____	_____	_____
4. _____	☐ yes ☐ no	_____	_____	_____
5. _____	☐ yes ☐ no	_____	_____	_____

Other than any children already indicated above, who lives in your household? _____

_____

_____

MARITAL STATUS:

Marital/relationship status (Check one) __Married; __Live with partner (same sex ___ or opposite sex___);

__Single; __Separated/Divorced; __Widowed; or Other: _____

EMPLOYMENT/EDUCATION INFORMATION:

Check all that apply: employed retired disabled student homemaker unemployed

If/When employed, what type of work do you do?_____

_____

_____

Current employer is:_____ Years on current job:_____

Highest degree completed in school: _____

HEALTH/MEDICAL INFORMATION:

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: _____
_____
_____
_____

Do any of these problems affect your everyday life? □ yes □ no If yes, how so? _____
_____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.): _____
_____
_____
_____

Have you ever blacked out / lost consciousness and/or experienced any type of serious head injury or trauma? □ yes □ no
If so, please indicate when and what happened.
_____
_____
_____

List all medications that you currently use:

Medication(s) _____
_____
_____
_____

Dosage (amount and times per day) _____

Reason(s)_____

Name of Medication Prescriber: _____

Name of Primary Care Physician (PCP): _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship _____

Address _____
(Street, Apt #) (City) (State) (Zip Code)

Telephone # Daytime _____ Evening _____

Cell Phone_____

Signature _____

Date _____