Restoration Counseling Service
INTAKE FORM

Please provide the following information and answer the questions below. Note that the information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session. Date: ___/___/___

Name: _____
(Last name) (First name) (Middle Initial)

Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ❑ Male ❑ Female

Marital Status:

❑ Never Married
❑ Married
❑ Separated
❑ Domestic Partnership
❑ Divorced
❑ Widowed

Please list any children and their ages:

_____

Your 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 note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
❑ No ❑ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? ❑ Yes ❑ No

Please list medication(s): _____
_____

Have you ever been prescribed psychiatric medication?
❑ Yes ❑ No
If so, please list and provide dates: _____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION
1. How would you rate your current physical health?
❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very good

Please list any specific health problems you are currently experiencing:
_____

2. How would you rate your current sleeping habits?
❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very good

Please list any specific sleep problems you are currently experiencing:
_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.
_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
❑ No ❑ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
❑ No ❑ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
❑ No ❑ Yes
If yes, please describe? _____

8. Do you drink alcohol more than once a week? ❑ No ❑ Yes

9. How often do you engage recreational drug use?
❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

10. Are you currently in a romantic relationship? ❑ No ❑ Yes
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse	❑ Yes	❑ No	_____
Anxiety	❑ Yes	❑ No	_____
Depression	❑ Yes	❑ No	_____
Domestic Violence	❑ Yes	❑ No	_____
Eating Disorders	❑ Yes	❑ No	_____
Obesity	❑ Yes	❑ No	_____
Obsessive Compulsive Behavior	❑ Yes	❑ No	_____
Schizophrenia	❑ Yes	❑ No	_____
Suicide Attempts	❑ Yes	❑ No	_____

ADDITIONAL INFORMATION:
1. Are you currently employed? ❑ No ❑ Yes
If yes, what is your current employment situation: _____
_____

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

2. Do you consider yourself to be spiritual or religious? ❑ No ❑ Yes

If yes, describe your faith or belief: _____

_____

_____

3. What do you consider to be some of your strengths? _____

_____

_____

_____

_____

_____

4. What do you consider to be some of your weakness? _____

_____

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

_____

_____

Thank you for taking the time to answer these questions to the best of your ability. This will assist greatly in making sure your time with me is focused and productive.
After filling this form out as completely as possible, please bring it with you to your first appointment.

Restoration Counseling Service
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