αlpha Family Practice
INTAKE FORM

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

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

Name of parent/guarding (if under 18 years)

_____
(Last) (First) (Middle Name or Initial)

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status:

☐ Never Married ☐ Domestic Partnership – How long? _____ ☐ Married – How long? _____
☐ Separated – How long? _____ ☐ Widowed – How long? _____
☐ Divorced – How long? _____

Address:

_____
(Street and Number) (City) (State) (Zip)

Telephone Number: (Home) _____ May I leave a message? ☐ Yes ☐ No

(Cell) _____ May I leave a message? ☐ Yes ☐ No

E-mail Address: _____ May I e-mail you? ☐ Yes ☐ No

*Please note: E-mail correspondence is not considered to be a confidential medium of communication.

Please list any children and their age: _____
_____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No
☐ Yes If yes, please list previous therapist/practitioner:

_____

_____

Are you currently taking any prescription medication?

☐ No

☐ Yes If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication?

☐ No

☐ Yes If yes, please list:

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific health problems you are currently experiencing?

_____

_____

How would you rate your sleeping habits?

Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific sleep problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise?

_____

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

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression?

☐ No

☐ Yes If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

☐ No

☐ Yes If yes, for approximately how long? _____

Are you currently experiencing any chronic pain?

☐ No

☐ Yes If yes, for approximately how long? Please describe:

_____

_____

_____

Do you drink alcohol more than once a week?

☐ No

☐ Yes If yes, how often? _____

How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, how long? _____

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

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

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In this 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, mother, grandmother, grandfather, uncle, etc.)

		List Family Member(s)
Alcohol/Substance Abuse	☐ Yes ☐ No	_____
Anxiety	☐ Yes ☐ No	_____
Depression	☐ Yes ☐ No	_____
Domestic Violence	☐ Yes ☐ No	_____
Eating Disorder	☐ Yes ☐ No	_____
Obesity	☐ Yes ☐ No	_____
Obsessive Compulsive Behavior	☐ Yes ☐ No	_____
Schizophrenia	☐ Yes ☐ No	_____
Suicide/Suicide Attempts	☐ Yes ☐ No	_____

ADDITIONAL INFORMATION:

Are you currently employed? ☐ Yes ☐ No If yes, what is your current employment situation?

_____
_____
_____

Do you enjoy your work? ☐ Yes ☐ No
Is there anything stressful about your current work? ☐ Yes ☐ No

Explain:

_____
_____
_____
_____

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No If yes, please describe your faith or belief:

_____
_____
_____

What do you consider to be some of your strengths?

_____
_____
_____

What do you consider to be some of your weaknesses?

_____
_____
_____

What would you like to accomplish in therapy?

_____
_____
_____
_____
_____

Is there any other pertinent information that you think will be helpful to us as we work together?

_____
_____
_____
_____
_____

_____ _____
Signature Date