INTEGRATIVE THERAPIES MEADVILLE
888 Market Street, Suite 2
Meadville, PA 16335
Phone: (814) 807-1300 Fax: (814) 807-1309

INTAKE FORM

Name _____ Date _____

Street Address _____

City _____ State _____ Zip Code _____

Mailing address (if different from above)_____

Telephone: Home _____ Work _____

Cell _____

E-mail address _____

Which is your preferred method of contact? _____

May we leave messages? Y / N

Male ____ Female ____ Date of Birth _____ Age _____

Person to call in case of emergency _____ Phone _____

Educational History

Highest grade completed: _____

Currently enrolled in school? _____ Where? _____

Employment History:

Are you currently employed? _____

If so, where are you employed? _____

Do you have concerns about work?_____

Spiritual/Religious History:

How important are your religious and spiritual beliefs and would you like to incorporate them into your therapy?

_____

_____.

Military Experience:

Have you had military experience? Y / N

If so, have you had combat experience? Y / N

Branch: _____ Date Enlisted/Drafted: _____

Discharge Date: _____ Type of Discharge: _____

Legal History:

Do you have any current legal difficulties (traffic, civil, criminal)? Y / N

Have you had any previous legal difficulties? Y / N

If yes, please describe: _____

_____

Relationship History:

Relationship status: Single_____ Married_____ Divorced_____

Spouse/partner name: _____

Children (names, ages): _____

Siblings (names, ages)" _____

Parents or step-parents (Ages or year of death): _____

_____

Medical history

Name of Doctor (Should you desire we make contact):_____

Address: _____

Doctor's Telephone Number: _____

Do you have a medical condition/s with which you are currently struggling or have, in the past, struggled? If so, please provide a brief summary.

_____

_____

Do you take any medicine every day? Y / N

Name, dosage & frequency: _____

_____

How many hours a night do you typically sleep? _____ Nap? _____

Mental Health History and Information:

Have you previously sought counseling services?

Check here if no _____

1. Psychotherapist name _____ Dates: _____ to _____

   Reason for seeking therapy _____

   Outcome _____

Have you ever been hospitalized for psychiatric reasons? Y / N
If yes, please describe, including dates:
_____

Substance Use:

How many alcoholic drinks do you have each week? _____

Do you smoke any cigarettes, cigars, pipes, or use chewing tobacco? Y / N

Do you use any other substances such as marijuana, heroin, cocaine, inhalants or prescription drugs? Y / N

Have you used any of these in the last 48 hours? Y / N

Have you used any of these in the last 30 days? Y / N

Is there a family history of problems with drugs or alcohols? Y / N

Have you ever received treatment for a substance abuse disorder? Y / N

If yes, please describe _____
_____

Current Concerns:
Please check any items that currently concern you:

- € Depressed mood
- € Anger
- € Anxiety
- € Sleep changes
- € Irritability
- € Impulsivity
- € Frequent sickness
- € Frequent tiredness
- € Muscle tension
- € Appetite or weight change
- € Restlessness
- € Racing heart
- € Difficulty breathing
- € Change in energy level
- € Distractibility
- € Recurring thoughts
- € Poor concentration
- € Infertility
- € Alcohol or drug use
- € Fears
- € Hopelessness
- € Sexual issues
- € Avoidance of people
- € Avoidance of situations
- € Suicidal thoughts
- € Confusion
- € Feeling numb
- € Visual hallucinations
- € Auditory hallucination
- € Other:

Do you have a family history of psychological problems, violence, or suicide?

_____

_____

Have you experienced traumatic events in your life? If so, please describe and give approximate dates.

_____

_____

_____

Who currently lives with you. Please include pets.

_____

_____

_____

What causes you stress?

_____

_____

_____

_____

How would you describe your social support network?

_____

_____

_____

_____

If there is anything else you would like to note, please do so here:

_____

_____

_____