COMPREHENSIVE CONFIDENTIAL INTAKE

IF THERE IS INSUFFICIENT SPACE, PLEASE FEEL FREE TO USE THE BACK SIDE OF THE FORM OR ADD MORE PAGES AS NEEDED.

Name:_____ Date: _____

Address:_____ Birthdate: _____

City/State/Zip:_____ Home Phone: _____

Email: _____ Work Phone: _____

How were you referred to me: _____ Cell Phone: _____

Profession: _____ Pronouns: _____

Sexual Orientation: ☐ Heterosexual ☐ Homosexual/Lesbian ☐ Pan/Bisexual ☐ Other: _____

Gender Identity: ☐ Male (Cis) ☐ Female (Cis) ☐ Transgender ☐ Transsexual ☐ Pangender/Androg.

☐ Intersex ☐ NonBinary ☐ Gender Queer ☐ Gender Questioning ☐ Other: _____

☐ Single ☐ Divorced ☐ Widowed ☐ Married/Partnered ☐ Boyfriend/Girlfriend ☐ Other: _____

Name of significant other(s) _____

Do you live together? Y / N If yes, how long? _____

Who (else) do you live with? _____

Please list the names of your parents (include stepparents), siblings, and yourself in order of age. _____

_____

_____

_____

If you have children please list their name, age and gender along with any other information about them you think it might be helpful for me to know (e.g. living arrangements, disabilities, etc)

_____

_____

_____

What are your main reasons for coming to see me? _____

_____

_____

_____

_____

Symptom Checklist: For each of the following items, please use numbers to indicate

0 = never; 1 = occasionally; 2 = sometimes: 3 = often 4 = always

Symptoms	Now	Past Year
Can't concentrate	0 1 2 3	0 1 2 3
Cry easily	0 1 2 3	0 1 2 3
Feel hopeless	0 1 2 3	0 1 2 3
Feel sad	0 1 2 3	0 1 2 3
Forgetfulness	0 1 2 3	0 1 2 3
Loss of appetite	0 1 2 3	0 1 2 3
Loss of interest	0 1 2 3	0 1 2 3
No desire to live	0 1 2 3	0 1 2 3
No energy	0 1 2 3	0 1 2 3
Nothing is fun	0 1 2 3	0 1 2 3
Think of suicide	0 1 2 3	0 1 2 3
Weight gain	0 1 2 3	0 1 2 3
Weight loss (without dieting)	0 1 2 3	0 1 2 3
Can't fall asleep	0 1 2 3	0 1 2 3
Feel worse in the AM	0 1 2 3	0 1 2 3
No need for sleep	0 1 2 3	0 1 2 3
Not feeling rested in the AM	0 1 2 3	0 1 2 3
Sleep too much	0 1 2 3	0 1 2 3
Waking up early	0 1 2 3	0 1 2 3
Buying sprees	0 1 2 3	0 1 2 3
Racing thoughts	0 1 2 3	0 1 2 3
Reckless driving	0 1 2 3	0 1 2 3
Restlessness	0 1 2 3	0 1 2 3
Talking too much	0 1 2 3	0 1 2 3
Uncontrollable urges	0 1 2 3	0 1 2 3
Anxiety attacks	0 1 2 3	0 1 2 3
Impatient	0 1 2 3	0 1 2 3
Panicky	0 1 2 3	0 1 2 3
Perseverating thoughts	0 1 2 3	0 1 2 3
Worry too much	0 1 2 3	0 1 2 3
Feeling isolated from others	0 1 2 3	0 1 2 3
Loneliness	0 1 2 3	0 1 2 3
Desire to physically hurt yourself	0 1 2 3	0 1 2 3
Feeling like you are not always in your body	0 1 2 3	0 1 2 3
Feeling that things are "unreal"	0 1 2 3	0 1 2 3
Flashbacks	0 1 2 3	0 1 2 3
Memory problems	0 1 2 3	0 1 2 3
Nightmares	0 1 2 3	0 1 2 3
Spacing out	0 1 2 3	0 1 2 3

Desire to physically hurt others	0 1 2 3	0 1 2 3

Symptom Checklist: For each of the following items, please use numbers to indicate

0 = never; 1 = occasionally; 2 = sometimes: 3 = often 4 = always

Symptoms	**Now**	**Past Year**
Explosive temper	0 1 2 3	0 1 2 3
Feel on edge	0 1 2 3	0 1 2 3
Feeling tense all the time	0 1 2 3	0 1 2 3
Feelings of inferiority	0 1 2 3	0 1 2 3
Guilt feelings	0 1 2 3	0 1 2 3
Irritable mood	0 1 2 3	0 1 2 3
Mood swings	0 1 2 3	0 1 2 3
Trouble getting along with others	0 1 2 3	0 1 2 3
Unnecessary or over-frequent washing	0 1 2 3	0 1 2 3
bad thoughts or feelings during sex	0 1 2 3	0 1 2 3
confused about your sexual feelings	0 1 2 3	0 1 2 3
Dissatisfied with sex life	0 1 2 3	0 1 2 3
Having sex you didn't enjoy	0 1 2 3	0 1 2 3
Low sex drive	0 1 2 3	0 1 2 3
sexual feelings when you shouldn't have them	0 1 2 3	0 1 2 3
Sexual overactivity	0 1 2 3	0 1 2 3
Sexual problems	0 1 2 3	0 1 2 3
Choking sensations	0 1 2 3	0 1 2 3
Dry mouth	0 1 2 3	0 1 2 3
Faintness/dizziness	0 1 2 3	0 1 2 3
Hyperventilation	0 1 2 3	0 1 2 3
Pounding heart	0 1 2 3	0 1 2 3
Sweating	0 1 2 3	0 1 2 3
Trembling	0 1 2 3	0 1 2 3
Passing out	0 1 2 3	0 1 2 3
Trouble breathing	0 1 2 3	0 1 2 3
Anxiety or fear of:		
Crowds	0 1 2 3	0 1 2 3
Dying	0 1 2 3	0 1 2 3
Elevators/escalators	0 1 2 3	0 1 2 3
Going crazy	0 1 2 3	0 1 2 3
Heights	0 1 2 3	0 1 2 3
Men	0 1 2 3	0 1 2 3
Public places	0 1 2 3	0 1 2 3
Stores	0 1 2 3	0 1 2 3
Talking in public	0 1 2 3	0 1 2 3
Women	0 1 2 3	0 1 2 3
Undifferentiated fears	0 1 2 3	0 1 2 3

Other:	0 1 2 3	0 1 2 3

Say more about anything you've checked: _____

Physical Condition Checklist: Physical issues can directly impact psychological functioning and vice versa. Check the conditions that apply to you now or in the past and add your comments to the side or below.

Musculo-Skeletal
- ❑ Arm/Hand pain
- ❑ Arthritis
- ❑ Back/Hip pain
- ❑ Bone/Joint Disease
- ❑ Broken/fractured bones
- ❑ Chest/ribs/abdominal pain
- ❑ Gout
- ❑ Headaches
- ❑ Joint stiffness/swelling/pain
- ❑ Leg/foot pain
- ❑ Muscle tension
- ❑ Osteoporosis
- ❑ Shoulder/neck pain
- ❑ Spasms/cramps
- ❑ Strains/sprains
- ❑ Tendonitis/Bursitis
- ❑ TMJD/Jaw pain
- ❑ Scoliosis
- ❑ Spinal cord injury
- ❑ Other_____

Skin/Soft tissue
- ❑ Acne
- ❑ Allergies
- ❑ Athletes Foot
- ❑ Eczema
- ❑ Rashes
- ❑ Ulcer
- ❑ Other_____

Sexual
- ❑ Erectile dysfunction
- ❑ Gender Dysphoria
- ❑ Premature ejaculation
- ❑ Painful intercourse
- ❑ Sexual aversion/lack of desire
- ❑ Other _____

Reproductive System
- ❑ Abortion
- ❑ Endometriosis/Fibroids
- ❑ Menopause-peri
- ❑ Menopause-post
- ❑ PMS/PMDD
- ❑ Pregnancy
  - ☐ Current ☐ Previous
- ❑ Other_____

Digestive/Urinary
- ❑ Chron's disease
- ❑ Chronic Nausea
- ❑ Constipation – Chronic
- ❑ Diarrhea - Chronic
- ❑ Diverticulitis or Colitis
- ❑ Indigestion
- ❑ Intestinal gas/bloating
- ❑ Interstitial cystitis
- ❑ Irritable bowel syndrome
- ❑ Other: _____

Circulatory and Respiratory
- ❑ Allergies
- ❑ Asthma
- ❑ Cold hands/feet
- ❑ Cold sweats
- ❑ Fainting
- ❑ Low or high blood pressure
- ❑ Lymphedema
- ❑ Heart Condition
- ❑ POTS
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Stroke
- ❑ Swollen ankles
- ❑ Varicose veins/Blood clots
- ❑ Other_____

Nervous System
- ❑ Chronic Pain
- ❑ Chronic Fatigue Syndrome
- ❑ Numbness/tingling
- ❑ Sleep disorder
- ❑ Paralysis
- ❑ Cerebral palsy
- ❑ Epilepsy
- ❑ Multiple sclerosis
- ❑ Muscular dystrophy
- ❑ Parkinson's disease
- ❑ Other_____

Virus/Bacterial
- ❑ Herpes/shingles
- ❑ HPV
- ❑ Lyme Disease (bacterial)

Other
- ❑ Cancer
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Ehlers Danlos
- ❑ Fibromyalgia
- ❑ Hearing Impaired
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ HIV/AIDS/Infections Condition
- ❑ Multiple Sclerosis
- ❑ Pernicious Anemia
- ❑ Sickle Cell Anemia
- ❑ Visually impaired
- ❑ Other _____

Comments for any check boxes on previous page:_____

Please describe any self-care practices (include exercise): _____

How would you describe your racial/ethnic/cultural background? _____

How would you define your faith system/religion and what spiritual practices do you engage in? _____

How would you describe your relationship with your body? _____

How do you express your sexuality/get your sexual needs met? _____

On average, how many hours per night do you sleep? _____

How would you describe your eating habits? _____

Sugar Intake: _____ Processed Food? _____ Caffeine: _____

Medications:

Current non-prescription medications, supplements & vitamins _____

Current prescription medications (include doses)_____

Previous/Discontinued prescription medications _____

Current Physicians	**Type of Care**
	Primary Health Care Provider

When was the last time you had a full physical evaluation? _____

Did you have a blood panel done at that time? ☐ Yes ☐ No

If so, what were the results? _____

Other medical history that hasn't been noted: _____

_____

_____

Psychedelics: Do you use psychedelics recreationally or therapeutically? Please describe.

_____

_____

_____

Chemical Dependency / Abuse History

1. Have you ever tried to cut down your drinking / drug use / gambling? Y / N
2. Have you ever thought that you had a problem with alcohol, drugs, or gambling? Y / N
3. Have you ever had negative consequences after drinking, using or gambling? Y / N
4. Has anyone ever suggested you have a problem with alcohol, drugs or gambling? Y / N
5. Have you ever used more than you intended to use or spent more than you intended? Y / N

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE COMPLETE THIS SECTION. IF NOT, SKIP TO MEDICATION SECTION.

Drug	Age of First Use	Last Use	Amount of Use	Frequency of Use	Route of Administration	Consider it a problem?
Alcohol						
Marijuana						
Cocaine						
Heroin						
Prescriptions						
Other						

Previous Treatment for Substance Abuse

Date	Who / Where	Type of Program	Outcome/Sobriety

Longest Period of Sobriety: _____ Longest Period of gambling absence: _____

Have you ever harmed yourself while under the influence? Y / N

Have you ever harmed anyone else while under the influence? Y / N

Age first gambled? _____ Most you've ever lost gambling? _____

How much technology/social media do you engage in per day or week? E.g. gaming, social media, etc: _____

Mental Health History: Have you been diagnosed with any mental condition or biochemical imbalance?

What is your history of physical, sexual, verbal or emotional abuse? _____

Are you a survivor of any other trauma that has not been named? _____

Have you ever attempted suicide? If so, please provide more info (e.g. number of attempts, age, circumstances)

History of Mental Health Treatment – Inpatient

Date	Hospital	Reason for Admission	Length of Stay

Total number of psychiatric hospitalizations: _____

History of Mental Health Treatment – Outpatient

Date	Who / Where	Reason for Seeking Services	Outcome or Benefit

Current Therapist/Healers **Type of Care**

Is there any other information that you think might be helpful in order to understand you and your needs better?

I certify that the responses are correct to the best of my knowledge. I agree to inform my provider should my physical or mental condition change.

Client Signature

Date