Better Days Telepsychiatry and Faith – Based Counseling

INTAKE FORM

Date of first appointment: _____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

Medical Provider: _____

Insurance Provider: _____

My Website:_____

Friend/Family: _____

Other: _____

Personal Information: Circle answers that are appropriate

Have you previously received any type of mental health services? Yes No

If yes, which of the following:

Psychotherapy

Medication

Out patient treatment

Inpatient Hospitalization Yes No

If yes, please provide:

Name of provider or facility:_____

Location:_____

Dates of treatment:_____

Reason for treatment:_____

Reason for Visit today:

Briefly describe

When did your problem first start? Within the last:

30 days

6--12 months

2 years

During adolescence

During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

Yes

No

If yes, for approximately how long? _____

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

Yes

No

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

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

_____

What would you like to accomplish out of your time in counseling?_____

_____

Family History:

Where were you born? _____

Where did you grow up? _____

City_____ Suburbs_____Country_____

Please list your parents_____

Did you have a good relationship with your parents? Yes No

Who did you live with growing up?_____

List siblings.

Name	Age	Good relationship (Y/N)	Where they live	If deceased, age and cause

Who did you live with while growing up?

_____

Mother's occupation: _____

Father's occupation? _____

Family 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.).

Condition: Please circle and List Family Member

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Sexual Abuse yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Disorder yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

Other diagnosed mental health condition? yes/no

Marital Status:

Never Married Domestic Partner Married Separated

Divorced -- For how long?

Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:

_____

On a scale of 1-10 (best), how would you rate your relationship?

_____

Are you currently in a romantic relationship?

Yes No How long? _____

Name of person in a relationship

If your significant other died, how did they die? _____

On a scale of 1-10 (best), how would you rate your relationship?

_____

Please list any children, their names, and ages:

Name	Age

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. If you have a

complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement Dosage Condition Date Began/Stopped

Prescribing provider, specialty, phone number:

Medication	Dose	Frequency	Prescriber	Reason

How would you rate your current physical health? Good___Poor___Average__

Please list any specific health problems you are currently experiencing:

_____

_____

How would you rate your current sleeping habits?

Poor___ Unsatisfactory___ Satisfactory___ Good____ Very Good____

If you are having problems, in which phase of sleep are you experiencing issues?

Falling asleep___Staying asleep___ Awakening early___ Sleep apnea___

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

_____

How many times per week do you generally exercise? _____ What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

No___ Yes____. If yes, please describe_____

Is there a history of alcohol, cigarettes, and/or recreational drugs: Yes__No___

If, describe_____

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? 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 weakness?