SARAH GENTRY
counseling

Intake Form

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

Please fill out this form and bring it to your first session.
Name: _____
Name of parent/guardian (if under 18 years):
_____

(Last) (First)
Birth Date: _____ /_____ /_____ Age: _____

My current gender identity is: _____

My sexual orientation is:_____

My sex assigned at birth is: _____

My pronouns are: _____

Relationship Status:

___Single __In relationship__Married __ Separated __Divorced __Widowed

Please list any children/age:
_____

Address:
_____

Home Phone: _____ Cell/Other Phone: _____

May we leave a message? □ Yes □ No May we leave a message? □ Yes □ No

E-mail: _____

May we 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, Name and Phone Number:
_____

Are you willing to sign a release for your previous therapist/practitioner?

_____

Are you currently taking any prescription medication? □ Yes □ No Please list:
_____
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No Please list and provide dates:
_____
_____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

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? (please circle)
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 If yes, how many times a week and how much?

_____

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

Anxiety

Depression

Domestic Violence

Eating Disorders

Obesity

Obsessive Compulsive Behavior

Schizophrenia

Suicide Attempts

List Family Member

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?

_____

_____

_____