Intake Form
Allison McGavin, M.Ed., LPC-MHSP

Name:____ Date:________________

Name of parent/guardian (if under 18 years): __________________________________

Referred By: ____

Birth Date: _______/_______/_______ Age: _______ Gender: Male Female

Address: ____

Primary Phone: _____________________________ May I leave a message? Yes No

Email: ____ May I email you? Yes No

Emergency Contact/Relationship: ____

Marital Status: Single Dating Cohabitating Engaged Married Separated

Divorced Widowed Other

If in a romantic relationship, how long? _______________________________________

On a scale of 1-10, how would you rate the relationship? (1=bad, 10=excellent) _______

Children/Age(s):____

Education Level: ____

Occupation: ____________________________ Employer: ________________________

Do you enjoy your work? Is there anything stressful about your current work?

____

____

Do you consider yourself spiritual or religious? Yes No Denomination: __________

Ethnic or Cultural Considerations: ____

Legal Issues: ____

Presenting Concerns: ____

____

Please check all that apply currently:

Nervousness	Depression	Loss/Grief Issues
Sleep Problems	Drug/Alcohol Use	Loneliness
Anger	Marital Problems	Pornography
Self-Worth	Financial Concerns	Parenting Problems
Sexual Compulsivity	Lack of Concentration	Suicidal Thoughts
Headaches	Stress	Problems at Work
Anxiety/Fears	Health Concerns	Separation
Trouble with Friends	Eating Disorder	Loss of Faith

All current medications: ____

____

Have you previously received mental health services? Yes No If yes, list below:
(Provider) (Type of treatment) (Dates)

____

____

____

Have you ever been prescribed psychiatric medication? Yes No If yes, provide dates and target issues:

____

____

Rate your physical health: Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

____

Rate your current sleep habits: Poor Unsatisfactory Satisfactory Good Very Good

Please describe any specific sleep problems:______________________________________

Rate your appetite/eating: Poor Unsatisfactory Satisfactory Good Very Good

List any concerns with appetite/eating patterns: ________________________________

____

How many times per week do you generally exercise? ________ What types of exercise do you participate in?____

Do you drink alcohol? Yes No How often/how many drinks per sitting? _________

Do you use any other substances? Yes No If yes, list substance and how often:

____

If no current substances, have they been used in the past? Yes No If yes, list:

____

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? ___________________________

Are you currently experiencing chronic pain? Yes No If yes, please describe:

____

Do you have any sexual concerns? Yes No If yes, do you wish to address in therapy? Yes No

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

____

____

What do you consider to be some of your strengths/limitations? ___________________

____

Who are your supports? ____

____

Please list any concerns that relate to immediate family members:__________________

____

In the section below, identify if there is a family history of the following issues:

(Issue)	(Yes/No)	(Family Member)
Alcohol/Substance Abuse	Yes No	
Anxiety	Yes No	
Depression	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Obsessive Compulsive Behavior	Yes No	
Schizophrenia	Yes No	
Suicide Attempts	Yes No	

Anything else you would like me to know? ______________________________________

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