Christine M. Valentin, LCSW, LLC

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Intake Form

Please provide the following information for my records. The following information allows me to get a better understanding of who you are and helps our therapeutic work together. If you feel uncomfortable answering anything, feel free to leave it blank.

Legal Name: _____
(Last) (First) (Middle Initial)

Name you preferred to be called: _____

Birth Date: _____ /_____ /_____ Age:_____ Gender: _____

Ethnicity:_____ Religion: _____ Practicing? Y / N

Marital Status:
__Never Married ____Partnered ____Married ____Separated ____Divorced ____Widowed

Occupation: _____ Education Level: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Primary Contact Number: ( ) _____ May I leave a message? ____ Yes ____ No

Person to Contact for Emergencies – Phone #, Address and Relationship: _____

_____

E-mail: _____

(Please note that e-mail correspondence is not considered to be a confidential way of communicating)

Referred By: __Psychology Today ____ HelpPro ____ Google Search ____Friend

____ Doctor _____ __ Therapist _____
(name) (name)

Why are you seeking therapy? _____

_____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

__Yes __No If Yes, with whom: _____

_____

Have you had psychotherapy in the past? __No __Yes

If Yes, when and by whom: _____

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Medications

Are you currently taking prescribed psychiatric medication (antidepressants, stimulants, etc.)?
___Yes ___No If Yes, please list medications and prescribing physician:

_____

_____

Have you been previously prescribed psychiatric medication? ___ Yes ___ No
If Yes, please list: _____

_____

Family

Do you have any children? ___Yes ____ No If yes, how old are they and what are their names?

Name: _____ Age: ___

Name: _____ Age: ___

Name: _____ Age: ___

Name: _____ Age: ___

Do you have any pets? ___ Yes ___ No If yes, what kind of pet and what is his/her name?

Name: _____ Type of Pet: _____ Age: _____

Name: _____ Type of Pet: _____ Age: _____

Stressors

What currently stresses you? _____

_____

_____

Goals for Treatment:

_____

_____

_____

_____

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Symptom Inventory and Treatment History

Rate the severity of the following symptoms **over the last month** according to the rating scale:
0- No difficulty 1- Mild difficulty 2- Moderate difficulty 3- Severe difficulty

___ Decreased Appetite
___ Increased Appetite
___ Binging/Purging (circle which one)
___ Increase in Weight
How many lbs? ____
___ Decrease in Weight
How many lbs? ____
___ Depressed Mood
___ Decreased Energy/ Fatigue
___ Changes in Sleep
_Trouble falling asleep
_Trouble staying asleep
_Trouble waking up
Average hours of sleep ____
___ Decreased Sexual desire
___ Difficulty with Sexual functioning
___ Loss of Interest in activities
___ Crying
___ Feeling of hopelessness
___ Feeling of helplessness
___ Decreased Attention span
___ Inattentive/Distractible
___ Memory Loss
___ Long-term
___ Short-term
___ Self-injurious behavior
___ Thoughts of Suicide
___ Thoughts of Hurting Others
___ Impulsive
___ Hyperactive
___ Anxiety/Nervousness
___ Worry/Fear
___ Flashbacks/Post Traumatic Stress
___ Nightmares
___ Hypervigilance
___ Obsessive thoughts
___ Compulsions
___ Spending sprees
___ Racing thoughts
___ Rapid heart beat
___ Trouble breathing
___ Sweating
___ Phobia
___ Police/Probation Involvement
___ Stealing
___ Lying
___ Violent behavior towards others
___ Destruction of property
___ Harming animals
___ Fire Setting
___ Opposition
___ Anger outbursts
___ Irritability

How many alcoholic drinks do you consume per week? _____

Do you smoke cigarettes? ____Yes ___No

Recreational drugs used in last two months? (Type/Frequency/Amount) _____

_____

Family history of substance abuse/ mental health problems _____

_____

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On a scale of 1 to 10 with ten being the highest, circle the number that represents how you would describe yourself.

	Not At All	Somewhat	Above Average	Agree
I am optimistic.	1 2	3 4 5	6 7 8	9 10
I am satisfied with my life.	1 2	3 4 5	6 7 8	9 10
I am satisfied with my health.	1 2	3 4 5	6 7 8	9 10
I am satisfied with my financial situation.	1 2	3 4 5	6 7 8	9 10
I am satisfied with my social life.	1 2	3 4 5	6 7 8	9 10

I certify the information I have provided is true and correct to the best of my knowledge.

Signed_____ **Date**_____