Christine M. Valentin, LCSW, LLC
127 Union Ave, Ste 4, Middlesex, NJ 08846
christine@cmvalentin.com (718) 314-9280 www.christinemvalentin.com

# 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

E-mail: _____
**(Please note: E-mail correspondence is not considered to be a confidential way of communicating)**

Would you like to receive appointment reminders via e-mail? ____ Yes ____ No

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

_____

Referred By: __Psychology Today ____ HelpPro ____ Google Search ____Friend

__ Doctor_____ __ Therapist _____
(name) (name)

Why are you seeking therapy? _____

_____

**(next page…)**

Christine M. Valentin, LCSW, LLC
127 Union Ave, Ste 4, Middlesex, NJ 08846
christine@cmvalentin.com (718) 314-9280 www.christinemvalentin.com

**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 with whom: _____

## 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 sibling(s)?** __Yes __ No If yes, how old are they and what are their names (first name only)?

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: _____

Christine M. Valentin, LCSW, LLC
127 Union Ave, Ste 4, Middlesex, NJ 08846
christine@cmvalentin.com (718) 314-9280 www.christinemvalentin.com

## Stressors

**What currently stresses you?** _____

_____

_____

**What Goals would you like to achieve in therapy?**

_____

_____

_____

_____

## Symptom Inventory

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
___ Crying

___ Loss of Interest in activities
___ 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 heartbeat
___ Trouble breathing
___ Sweating
___ Phobia
___ Police/Probation Involvement
___ Stealing
___ Lying
___ Violence towards others
___ Destruction of property
___ Harming animals
___ Fire Setting
___ Opposition
___ Anger outbursts
___ Irritability

**(next page…)**

**How many alcoholic drinks do you consume per week?** _____

**Do you smoke cigarettes?** ___Yes __No

Christine M. Valentin, LCSW, LLC
127 Union Ave, Ste 4, Middlesex, NJ 08846
christine@cmvalentin.com (718) 314-9280 www.christinemvalentin.com

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

**Family history of substance abuse/ mental health problems** _____
_____

**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 | Agree | Above Average |
|---|---|---|---|---|
| **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**_____