

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

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...)

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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: _____

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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

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

How many alcoholic drinks do you consume per week? _____

Do you smoke cigarettes? ___Yes ___No

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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** _____