

PACIFIC ASSISTANCE GROUP

A PROFESSIONAL FAMILY THERAPY CORPORATION

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 or return it to the Area Administrator or Case Manager with whom you have been in contact.

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

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: (_____) _____ May we leave a message? Yes No

Cell/Other Phone: (_____) _____ May we leave a message? Yes No

Work/Other Phone: (_____) _____ 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.

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Social Security: ____/____/____ Ethnicity: _____

Are you currently employed? No Yes

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

PLEASE COMPLETE AND PROVIDE TO YOUR AREA ADMINISTRATOR

Employer: _____ (Name)
_____ (Address)
_____ (City/State/Zip)
Contact _____ Telephone () _____ - _____

Specialty / Board Certifications: _____

Hospital: _____ (Name)
_____ (Address)
_____ (City/State/Zip)
Contact _____ Telephone () _____ - _____

Marital Status:
 Never Married Domestic Partnership Married Separated
 Divorced Widowed

On a scale of 1 to 10, how satisfied are you with your current relationships or status? _____

Please list any children/age: _____

Referred by (if any): _____
May we contact this person to let him/her know you have called? Yes No

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
 No
 Yes, 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 currently drink alcohol more than once a week? No Yes
9. How often do you engage recreational drug use? Daily Weekly Monthly
 Infrequently Never
10. If you are in recovery, please list your sober date: _____
11. Have you received treatment for alcohol or drug problems in the past? If so, please list previous treatment experiences and dates:

<u>Treatment /Type</u>	<u>Dates</u>
_____	_____
_____	_____
_____	_____

12. 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.).

	<u>Please Circle</u>	<u>List Family Member</u>
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	

ADDITIONAL INFORMATION:

13. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

14. What do you consider to be some of your strengths?

15. What do you consider to be some of your weakness?

16. What would you like to accomplish out of your time in recovery support and monitoring?
