Wellness From Within, P.C.

I N T A K E F O R M

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.

General Information

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

Referred by (if any): _____

Ethnicity: __Anglo, __Hispanic/Latino, __Black/ African-American, __Native American, __Asian, Other:_____

Languages Spoken: English, Spanish, Other:_____

Are there any religious or cultural preferences that you would like us to be aware of?

_____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □ No □ Yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Please list any children/age: _____

Who resides with you in your home? _____

Family History

1. 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.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

2. Please describe your relationship with your parents:

_____

_____

3. Please describe your relationship with any siblings if applicable:

_____

_____

4. Please describe your relationship with your partner if applicable:

_____

_____

Social Support/History

1.Who can you call for support, what activities do you enjoy doing, and where do you get emotional support?

_____

_____

Educational/occupational history

1. What is the last year that you completed in school?

_____

2. Are you currently employed? □ No □ Yes, what type of employment:

_____

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

_____

Present Symptoms

1.Please describe any physical or mental health concerns that you are CURRENTLY experiencing (anxiety, depression, grief, chronic pain, difficulty sleeping, self-harm, harm to others, etc.):

_____

_____

2. When did you begin experiencing these symptoms?

_____

_____

3. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes, for approximately how long? _____

4. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes, when did you begin experiencing this? _____

5. Are you currently experiencing any chronic pain?
□ No
□ Yes, please describe _____

6. 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:

_____

7. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

8. Please list any difficulties you experience with your appetite or eating patterns

_____

9. What will be different in your life due to participating in therapy?

_____

_____

Current Medications:

Please list any medications that you are currently taking along with the dosage, what it is for and the doctor that prescribed the medication:

_____

_____

Medical Conditions and History

1. Do you have any allergies (i.e. medications, foods, chemicals)?
□ No
□ Yes, please list: _____

2. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you have:

_____

_____

Psychiatric History

1.Are you currently having any self-harming thoughts? □ No □ Yes

2. Are you currently having any thoughts to hurt others? □ No □ Yes

3. Have you experienced any self-harming thoughts in the past? □ No □ Yes

If yes, please explain:

_____

4. Have you experienced any thoughts to hurt others in the past? Yes □ No □

If yes, please provide additional information:

_____

5. Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalizations, etc.)?
□ No
□ Yes, previous providers & dates: _____

6. Please list any mental health conditions that you have been diagnosed with in the past:

_____\

_____

Trauma History

1.Any significant childhood history (i.e. trauma, abuse, foster care): _____

_____

_____

2. What significant life changes or stressful events and when did the change or event occur?

_____

_____

Substance Abuse

1. Do you drink alcohol more than once a week? □ No □ Yes, how much_____
Do you smoke? □ No □ Yes, how much_____

2. How often do you engage recreational drug use?
□ Never □ Infrequently □ Monthly □ Weekly □ Daily

3. If engaging in recreational drug use currently, which drugs are you utilizing (please include illicit and prescription drugs)? Please include the date of last use as well as when you first started to use the substance:

_____

Developmental History

Have you been diagnosed with any developmental delays or disabilities? If yes, please list

_____

_____

Legal History

Please list any experiences that you have had with the legal system to include divorce, arrest, sentencing, DUI occurrences, incarceration and litigation:

_____

_____

Strengths/Limitations

1. What will be different in your life due to participating in therapy?

_____

_____

2. What do you are your strengths?

_____

_____

2. What do you see are challenges to overcome?

_____

_____

Other Information

Is there anything else you like to share?

_____

_____

_____