Wilson Psychological
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CONFIDENTIAL INTAKE FORM

- Please print out and complete this form and bring it with you to your first session.
- Please bring a government-issued identification card to your first session.
- Please provide the following information.

NAME:

_____ _____ _____
(Last Name) (First Name) (Middle Name)

BIRTH DATE: **AGE:** **GENDER:**

_____ / _____ / _____ _____ ☐ Male ☐ Female
(Month) (Day) (Year)

MARITAL STATUS:

☐ Never Married ☐ Separated
☐ Domestic Partner ☐ Divorced
☐ Married ☐ Widowed

CHILDREN & THEIR AGE:

_____

ADDRESS:

_____
(Street and Number)

_____ _____ _____
(City) (State) (Zip Code)

HOME PHONE: _____
May I leave a message?
⬜ Yes ⬜ No

CELL PHONE: _____
May I leave a message?
⬜ Yes ⬜ No

EMAIL: _____
May I email you?
⬜ Yes ⬜ No

What is your preferred method of communication? _____

WERE YOU REFERRED BY SOMEONE? IF SO, WHO?

_____

HAVE YOU PREVIOUSLY RECEIVED ANY TYPE OF MENTAL HEALTH SERVICES? (such as: psychological, psychiatric, counseling, etc)

⬜ Yes ⬜ No

LIST PREVIOUS THERAPISTS (OR DOCTORS) AND TREATMENT RECEIVED:

_____

_____

ARE YOU CURRENTLY PRESCRIBED ANY PSYCHIATRIC MEDICATION:
⬜ Yes ⬜ No

Medication: _____ Dose: _____ Prescriber:_____
Medication: _____ Dose: _____ Prescriber:_____
Medication: _____ Dose: _____ Prescriber:_____

ARE YOU TAKING ANY MEDICATIONS OF ANY KIND? LIST:

_____

ARE YOU TAKING ANY VITAMINS, MINERALS, HERBS ETC? LIST:

_____

GENERAL & MENTAL HEALTH

HOW WOULD YOU RATE YOUR CURRENT <u>PHYSICAL</u> HEALTH:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

Please list any physical symptoms and diagnoses:

_____

HOW WOULD YOU RATE YOUR CURRENT <u>COGNITIVE</u> HEALTH:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

Please list any physical symptoms and diagnoses:

_____

HOW WOULD YOU RATE YOUR CURRENT <u>EMOTIONAL</u> HEALTH:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

Please list any physical symptoms and diagnoses:

_____

HOW WOULD YOU RATE YOUR CURRENT <u>QUALITY OF SLEEP</u>:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

Are you experiencing any of the following:

⬜ Difficulty falling asleep?
⬜ Difficulty staying asleep?
⬜ Nightmares?
⬜ Night Terrors?

HOW WOULD YOU RATE YOUR CURRENT <u>APPETITE</u>:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

Any recent weight gain? ⬜ Yes ⬜ No

Any recent weight loss? ⬜ Yes ⬜ No

Any GI issues? ⬜ Yes ⬜ No

HOW WOULD YOU RATE YOUR CURRENT <u>LIBIDO</u>:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

HOW WOULD YOU RATE YOUR CURRENT <u>ATTENTION & CONCENTRATION</u>:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

HOW WOULD YOU RATE YOUR CURRENT <u>ABILITY TO BE MINDFUL</u>:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

HOW WOULD YOU RATE YOUR CURRENT <u>QUALITY OF SLEEP</u>:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

HOW WOULD YOU RATE YOUR ABILITY TO REMAIN <u>PRESENT IN THE MOMENT</u>:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

HOW WOULD YOU RATE YOUR <u>ENERGY LEVELS</u>:

⬜ Poor ⬜ Unsatisfactory ⬜ Satisfactory ⬜ Good ⬜ Excellent

WOULD YOU CONSIDER YOURSELF:

⬜ Physically restless
⬜ Fidgety
⬜ Uneasy
⬜ Without purpose

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING GRIEF, SADNESS, DEPRESSION?

⬜ Yes ⬜ No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING ANXIETY, PANIC ATTACKS, PHOBIAS?

⬜ Yes ⬜ No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING WORRY, RACING THOUGHTS, CONTINUOUS THOUGHTS?

⬜ Yes ⬜ No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING ANY PHYSICAL PAIN?

⬜ Yes ⬜ No

If yes, for how long? _____)

Type and location of pain: _____)

Intensity of pain on scale of 1 to 10: _____)

HOW OFTEN DO YOU EXERCISE?

_____

HOW OFTEN DO YOU MEDITATE?

_____

HOW MANY LITERS OF WATER DO YOU DRINK PER DAY?

_____

HOW OFTEN DO YOU SPEND TIME OUTDOORS?

_____

HOW OFTEN ARE YOU LEARNING OR DOING NEW THINGS?

_____

HOW OFTEN DO YOU USE:

Alcohol?	Cigarettes?	Marijuana?	Recreational drugs of any type?
⬜ Yes ⬜ No	⬜ Yes ⬜ No	⬜ Yes ⬜ No	⬜ Yes ⬜ No

How often?	How often?	How often?	If yes, which??
_____	_____	_____	_____

Do you use any other form of drug to escape or numb emotional pain?
⬜ Yes ⬜ No

If so, which?
_____

ARE YOU CURRENTLY IN A ROMANTIC RELATIONSHIP? ⬜ Yes ⬜ No
On a scale of 1-10, how would your rate your current relationship? _____

ARE YOU CURRENTLY EXPERIENCING ANY SIGNIFICANT LIFE SITUATIONS, LIFE CHANGES, OR STRESSORS?

_____

_____

_____

_____

FAMILY MENTAL / EMOTIONAL HEALTH HISTORY
Has anybody in your family experienced any of the following conditions?

Anxiety:	⬜ Yes	⬜ No	Relationship: _____
Depression:	⬜ Yes	⬜ No	Relationship: _____
Substance Abuse:	⬜ Yes	⬜ No	Relationship: _____
Suicide Attempts:	⬜ Yes	⬜ No	Relationship: _____
Mental Disorder:	⬜ Yes	⬜ No	Relationship: _____
Dementia:	⬜ Yes	⬜ No	Relationship: _____
Violence:	⬜ Yes	⬜ No	Relationship: _____

List any other family history:

_____

_____

ADDITIONAL INFORMATION:

HIGHEST EDUCATION LEVEL COMPLETED: _____

ARE YOU CURRENTLY EMPLOYED?

⬜ Yes ⬜ No

If yes, what is your profession? _____

DO YOU FEEL THAT YOUR CURRENT EMPLOYMENT/ WORK IS REWARDING?

⬜ Yes ⬜ No

ARE YOU A SPIRITUAL OR RELIGIOUS PRACTITIONER?

⬜ Spiritual ⬜ Religious ⬜ Both ⬜ None

If yes, please describe your belief, faith, or practices?

_____

_____

WHAT WOULD YOU SAY ARE YOUR STRENGTHS?

_____

_____

WHAT WOULD YOU LIKE TO ACCOMPLISH THROUGH THERAPY?

_____

_____

_____

_____

ADDITIONAL NOTES:

_____

_____

_____

_____

_____