Michele Akers-Woody, Psy.D.

Intake Form

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

Name: _____

Name of parent/guardian (if under 18 years):_____

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

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

Emergency Contact Name & Relation:_____

Emergency Contact Phone: _____

Address: _____

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

Cell/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.

Referred by (if any): _____

Please tell me what is bringing you or your child into therapy at this time:

_____

_____

_____

_____

_____

MENTAL HEALTH INFORMATION & HISTORY:

Please put a mark by any of the following that you have experienced in the last 3 months:

	Increased/decreased appetite		Lack of energy/lethargy
	Isolating from others		Repetitive behavior
	Loss if interest in things		Relationship issues
	Feeling empty		Recurring thoughts
	Hopelessness		Extreme worry and rumination
	Crying spells		Nightmares
	Increased fears		Flashbacks
	Sleep problems		Too much energy
	Short attention span		Trouble focusing/concentrating
	Increased anger		Sexual issues
	Abuse of alcohol and/or drugs		Memory problems
	Feeling paranoid		Racing thoughts
	Increased irritability		Mood swings
	Nervousness		Violent actions
	Panic attacks		Changes in weight
	Easily frustrated		Feeling stressed
	Low self-esteem		Depressed mood
	Anxiety		Unusual or extreme euphoria
	Changes in personality		Recklessness
	Self-hate		Procrastination
	Confusion		Hearing voices that others don't
	Seeing things that others don't		Disorientation
	Several physical complaints		Self-harm
	Pulling out hair		Skin-picking
	Suicidal ideation		Suicide attempt

Are there any other symptoms that you have experienced in the last 3 months that are not listed?

_____

Have you **ever** received any type of mental health counseling/therapy (i.e. individual/ couple/ family/group/PHP/IOP)?

□ No □ Yes

If yes, previous therapist/psychologist, modality, approx. dates of service, & known diagnosis(es):

_____

_____

Have you **ever** received any type of psychiatric services?
□ No □ Yes
If yes, previous psychiatrist, approx. dates of service, & known diagnosis(es):

_____
_____

Have you **ever** been prescribed psychiatric medication?
□ No □ Yes
If yes, prescribing physician, medications prescribed, & dates:

_____
_____

Have you **ever** been psychiatrically hospitalized?
□ No □ Yes
If yes, facility and dates of hospitalization:

_____
_____

Have you **ever** received any type of substance abuse treatment (i.e. outpatient, inpatient, 12-step)?
□ No □ Yes
If yes, therapist/facility/program and dates:

_____
_____

Have you **ever** experienced suicidal ideation (thoughts of suicide)?
□ No □ Yes
If yes, please list when and describe:

_____
_____

Have you **ever** had a suicide attempt?
□ No □ Yes
If yes, please list when and describe:

_____
_____

Have you **ever** engaged in self-harm (i.e. cutting, burning)?
□ No □ Yes
If yes, please list when and describe:

_____
_____

Have you **ever** experienced overwhelming sadness, grief, and/or depression?
□ No □ Yes
If yes, please list when and describe:

_____
_____

Have you **ever** experienced a hypomanic/manic episode (excessive energy with loss of sleep)?
□ No □ Yes
If yes, please list when and describe:

_____

_____

Have you **ever** experienced extreme mood swings?
□ No □ Yes
If yes, please list when and describe:

_____

_____

Have you **ever** experienced anxiety and/or panic attacks?
□ No □ Yes
If yes, please list when and describe:

_____

_____

Have you **ever** experienced what you would call a “nervous breakdown”?
□ No □ Yes
If yes, please list when and describe:

_____

_____

Have you **ever** had any excessive fears or phobias?
□ No □ Yes
If yes, please list when and describe:

_____

_____

Have you **ever** seen, heard, or felt things that were not really there?
□ No □ Yes
If yes, please list when and describe:

_____

_____

Have you **ever** experienced a flashback in which you felt that you were reliving something?
□ No □ Yes
If yes, please list when and describe:

_____

_____

Have you **ever** excessively used or abused alcohol or drugs?
□ No □ Yes
If yes, please list when and describe:

_____

_____

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 (i.e. father, mother, son, daughter, etc.)

Depression:	□ No	□ Yes	_____
Bipolar/Manic Depression:	□ No	□ Yes	_____
Anxiety:	□ No	□ Yes	_____
Panic Attacks:	□ No	□ Yes	_____
OCD Behavior:	□ No	□ Yes	_____
PTSD:	□ No	□ Yes	_____
ADHD:	□ No	□ Yes	_____
Eating Disorder:	□ No	□ Yes	_____
Borderline Personality:	□ No	□ Yes	_____
Schizophrenia:	□ No	□ Yes	_____
Alcohol/Substance Abuse:	□ No	□ Yes	_____
Self-Harm:	□ No	□ Yes	_____
Suicide Attempts:	□ No	□ Yes	_____
Suicide Completion:	□ No	□ Yes	_____

GENERAL HEALTH INFORMATION:

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:

_____

Please list any prior health problems for which you have experienced:

_____

Are you currently or have you **ever** experienced any chronic pain?

□ No □ Yes

If yes, please list and describe:

_____

_____

Are you currently or have **ever** been prescribed long-term use of pain medications/opioids?

□ No □ Yes

If yes, please list and describe:

_____

_____

Are you currently taking any medication(s) (non-psychotropic and non-opioid)?
□ No □ Yes
If yes, please list medication and condition for which it treats:
_____
_____

Are you currently taking any Supplements?
□ No □ Yes
If yes, please list the supplement and reason for taking:
_____
_____

How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

How many hours of sleep go you get on average per night? _____

Please list any specific sleep problems you are currently experiencing:_____
_____

How many times per week do you generally exercise & what types of exercise do you do?_____
_____

Please list any difficulties you experience with your appetite or eating patterns:_____
_____

Do you drink soda/coffee/energy drinks or anything else that contains caffeine?
□ No □ Yes
If yes, please describe your use:_____

Do you smoke cigarettes/cigars, use e-cigarettes/juuls (vape), or chew/use oral tobacco?
□ No □ Yes
If yes, please describe your use:_____

How often you drink alcohol (i.e. beer, wine, hard liquor)?
□ Daily □ Weekly □ Infrequently □ Never

If you do drink alcohol, what do you drink and how much do you consume?_____
_____

How often do you use any illicit drugs (i.e. marijuana) or non-prescribed medications (i.e. opioids)?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

If you do use illicit drugs/non-prescribed medications, what do you use and how much do you use?_____
_____

PSYCHOSOCIAL INFORMATION:

What sexual orientation do you identify?
□ Heterosexual (straight) □ Homosexual (gay/lesbian) □ Bi-sexual □ Other _____

Current Relationship Status:

□ Never married, currently single: How long have you been single?_____

□ Never married, in a relationship: How long have you been in a relationship?_____

Boyfriend's/Girlfriend's name:_____

On a scale of 1-10 (poor – wonderful), how would you rate your relationship:_____

□ Domestic partnership: How long have you been with your partner?_____

Partner's name:_____

On a scale of 1-10 (poor – wonderful), how would you rate your relationship:_____

□ Married: How long have you been married?_____

Spouse's name:_____

On a scale of 1-10 (poor – wonderful), how would you rate your relationship:_____

□ Separated: How long have you been married?_____

How long separated?_____

Spouse's name:_____

□ Divorced, currently single: How long have you been divorced?_____

□ Divorced, in a relationship: How long have you been divorced?_____

How long have you been in a relationship?_____

Boyfriend's/Girlfriend's/Partner's name?_____

On a scale of 1-10 (poor – wonderful), how would you rate your relationship:_____

□ Widowed, currently single: How long have you been widowed?_____

□ Widowed, in a relationship: How long have you been widowed?_____

How long have you been in a relationship?_____

Boyfriend's/Girlfriend's/Partner's name?_____

On a scale of 1-10 (poor – wonderful), how would you rate your relationship:_____

Please describe your relationship history not listed above:_____

_____

Please list any children and their age(s):_____

_____

Are you currently employed? □ No □ Yes

If yes, what is your current occupation and where do you work?

_____

Do you work: □ Full-time □ Part-time □ Per-diem, on-call

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

_____

_____

Are you a student: □ No □ Yes

If yes, where to you go to school and what are you studying?_____

_____

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

If yes, describe your faith or belief:_____

_____

ADDITIONAL INFORMATION:

What significant life changes or stressful events have you experienced in the last year?_____

_____

_____

_____

Please list any traumatic events that you have experienced in your life that is not listed above:_____

_____

_____

_____

What do you consider to be some of your strengths?_____

_____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

_____

_____

Is there anything else that I should know about you that has not already been mentioned?_____

_____

_____

Lastly, what would you like to accomplish out of your time in therapy?_____

_____

_____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM!