Intake Form

Client Name ____Date ___________________

DOB ____/____/________ Age _________________SSN _________________________________

Address ____

Phone _______________________________ Email _____________________________________

Marital Status _________________________ Race/Ethnicity _____________________________

Emergency Contact________________________________ Phone __________________________

Relation to Patient____

Name of Insurance Company ____

Phone _________________________ Mental Health Carrier_______________________________

Phone__________________________ (If Different from Primary Insurance Carrier)

Name of Policy Holder____

Relation to Patient_______________________

Policy Holder DOB ____/____/_____ SSN of Policy Holder______________________________

Policy Number __________________________ Group Number___________________________

Name/address of your primary care physician or psychiatrist.

____

4785 Memphis Avenue, Cleveland, OH 44144 | Phone: 216-563-1180 | Fax: 440-815-2245 | egchupa@bwscleveland.com

Personal History

How did you find out about our practice? ____

What concerns are you currently experiencing that should be addressed in therapy?

____
____
____
____

Are you currently on any medication? ____

____

What do you consider to be your strengths? ____
____
____
____
____

What do you like most about yourself? ____
____
____
____
____

What are effective coping strategies that you have learned? ______________________________
____
____
____
____

What are your goals for therapy? ____
____
____
____
____

Mental Health History

If applicable, please describe your previous mental health treatment:

When	Where	Name of Health Professional	Purpose of Treatment	Results	Reason for Terminating Treatment

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

Occupational Information

Are you currently employed? Yes____ No____

If yes, who is your currently employer/position? ____

If yes, are you happy with your current position? ____

Please list any work-related stressors, if any ____

____

Religious/Spiritual Information

Do you consider yourself to be religious? Yes____ No____

If yes, what is your faith? ______________________________

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

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