Elizabeth Boyle Psychological Services
I N TA K E F O R M

Please provide the following information and bring this form to your first session.

Please note: The information you provide here is protected and confidential information by HIPAA regulations and in accordance with rules of the Minnesota Board of Psychology.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Address: _____
(Number and Street) (City) (State) (Zip)

Home Phone: (_____) May we leave a message? _____
Cell/Other Phone: (_____) May we leave a message? _____

Relationship Status: (circle one) Single Married Divorced Partnered Widowed

Are you currently in a committed or serious relationship? _____ If so, for how long and state partner's name please. _____

Please list any children and their names and ages: _____
_____
_____

Have you previously received any type of mental health services (psychotherapy, day treatment, and/or psychiatric services? If so, when and where and was it helpful? _____
_____

Are you currently taking any prescription medication? If so, please list medications, dosage and provider: _____
_____

Have you ever been prescribed psychiatric medications? If so, please list the medication/s, approximate dates taken, and the provider: _____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Satisfactory Good Very good Excellent

Please list any specific health problems you are currently experiencing or that have been serious issues for you in the past: _____

2. How would you rate your current sleeping habits and/or quality of your sleep? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

_____

3. How many times per week do you generally exercise and what type? _____

_____

4. Please list any difficulties you have with your appetite or eating patterns now or in the past: _____

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? _____
If yes, for approximately how long has this lasted? _____

6. Do you currently feel overwhelming stress, anxiety, panic attacks, or have any phobias (specific fears)? _____

If yes, when did you begin experiencing this? _____

7. Do you have chronic pain issues? _____
If yes, please describe the nature and state for how long you have had it: _____

_____

8. Do you drink alcohol? _____ If so, how often and how much? _____

_____

9. Do you use other drugs or abuse prescription medications? _____ If so, what and how often? _____

_____

10. What, if any, 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, then Please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

***This includes immediate family members and extended blood relatives

Please Circle: **Yes** or **No** and LIST THE FAMILY MEMBER

Alcohol/Substance Abuse	Yes/No	Schizophrenia/other Serious Mental Illness	Yes/No
Anxiety	Yes/No	Suicide or attempts	Yes/No
Depression	Yes/No	Obsessive Compulsive Disorder (OCD)	Yes/No
Domestic Violence or Abuse	Yes/No	Eating Disorders	Yes/No
Obesity	Yes/No	Others	

ADDITIONAL FAMILY AND SOCIAL INFORMATION

Please state your general relationship with your family and/or family of origin and whether there are any significant problems _____

_____

Do you have a sound support system and/or friends? If so, please give a general idea of who this includes _____

What kind of leisure activities do you enjoy? _____

ADDITIONAL INFORMATION:

1. Are you currently employed? _____ If yes, what is your current employment situation? _____

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

_____

_____

If you are a student, please state where and what are you studying _____

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2. Do you consider yourself to be spiritual or religious? _____If yes, describe your faith or beliefs: _____

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

_____

_____

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

_____

_____

5. What would you like to accomplish out of your time in therapy? _____

_____

_____

6. Is there anything else that you think is important for your therapist to know about you before beginning therapy? _____

Referred by (if any): _____