ARANA HAGAN COUNSELING

I N T A K E F O R M

Please answer the questions below. Please note: information you provide here is protected as confidential information. PLEASE DO NOT EMAIL THIS FORM – bring it to your first appointment.

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

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

Marital Status:
Never Married Domestic Partnership Married
Separated Divorced Widowed

If single, widowed or divorced: Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

If married or in a relationship: On a scale of 1-10, how would you rate your relationship? _____

Please list any children/age: _____

_____

Referred by (if any): _____

Are you currently seeing a Counselor, Psychiatrist or Psychologist? Yes No

If Yes, would you like for us to communicate with each other? Yes No
If yes, I will need written permission to share information.

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Yes No
If Yes
Approximate length of treatment, how long ago and did you consider it to be successful?

_____

_____

_____

_____

Are you currently taking any prescription medication? Yes No

Please list: _____

_____

Have you ever been prescribed psychiatric medication? Yes No

Please list and provide dates (if known):_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. 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:

_____

_____

2. 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:

_____

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

What types of exercise to you participate in? _____

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

_____

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5. Are you currently experiencing overwhelming sadness, grief, or depression? No Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? No Yes

If yes, please describe _____

_____

7. Are you currently experiencing any chronic pain? No Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? No Yes

If yes, how often? _____

9. Do you engage recreational drug use? No Yes

10. Please rate your current level of stress 1 = no stress 10 – most severe

1 2 3 4 5 6 7 8 9 10

11. Please list any significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, please circle 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	**Family Member**
Alcohol/Substance Abuse	_____
Anxiety	_____
Depression	_____
Domestic Violence	_____
Eating Disorders	_____
Obesity	_____
Obsessive Compulsive Behavior	_____
Schizophrenia	_____
Suicide Attempts	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

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

_____

_____

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

If yes, describe your faith or belief if you are comfortable doing so:

_____

_____

3. What do you consider to be your strengths?

_____

_____

_____

_____

4. What do you consider to be your challenges?

_____

_____

_____

_____

5. What is the primary reason you have decided to seek therapeutic help?

_____

_____

6. What would you like to accomplish during your time in therapy?

_____

_____

7.. How will you know if you have met your goals for therapy?

_____

_____