

Restoration Counseling Service
INTAKE FORM

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

Please fill out this form and bring it to your first session. Date: ___/___/___

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

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

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

Marital Status:

- | | |
|--|---|
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Domestic Partnership |
| <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Widowed |

Please list any children and their ages:

Your address: _____
(Street and Number)

_____ (City) (State) (Zip)

Home Phone: (____) ____ - _____ May I leave a message? Yes No

Cell/Other Phone: (____) ____ - _____ May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? Yes No

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Please list medication(s): _____

Have you ever been prescribed psychiatric medication?

Yes No

If so, please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

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?

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 do you participate in: _____

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

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, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

No Yes

If yes, please describe? _____

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

9. How often do you engage recreational drug use?
 Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What 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, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

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

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If yes, describe your faith or belief: _____

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

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

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

Thank you for taking the time to answer these questions to the best of your ability. This will assist greatly in making sure your time with me is focused and productive.

After filling this form out as completely as possible, please bring it with you to your first appointment.

Restoration Counseling Service
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