Charlotte Malkmus, MA, LMHC
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Intake Form

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

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

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

_____
(First) (Middle Initial) (Last)

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

SSN#: _____ Employer: _____

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age(s): _____

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

Preferred Phone:_____ May I leave a message? □ Yes □ No

Email: _____ May I email you? □ Yes □ No

Referred by (if any): _____

Have you received any type of mental health services before (e.g. counseling, psychiatric services)? □ No □ Yes

If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:

_____

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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 do you do? _____

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

_____

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

If yes, for approximately how long?

_____

How would you rate the severity of these feelings? (please circle)

Mild Moderate Severe Extreme

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

If yes, when did you begin experiencing this? _____

How would you rate the severity of these feelings? (please circle)

Mild Moderate Severe Extreme

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: _____

How would you rate the severity of these feelings? (please circle)

Mild Moderate Severe Extreme

8. How often do you currently drink alcohol? _____ drinks per _____

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

Which drugs? _____

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 satisfaction with your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

__ Serious illness or injury
__ Major illness in family
__ Divorce/Separation
__ Move to new home
__ Death of a close friend or family member
__ Gain of new family member
__ Job change
__ Other

12. Have you ever had difficulty with the law, or been arrested? _____

_____

13. Are you currently involved in a legal dispute (for example, lawsuit, custody dispute)?

_____

14. Have you ever had thoughts of harming yourself? _____ Do you currently have such thoughts?_____

15. Have you ever had serious thoughts of harming someone else? _____
Do you currently have such thoughts? _____

16. Have you ever made a suicide attempt? _____ If so, please give dates _____

17. How likely are you to harm yourself or someone else at this time? (Circle best answer)

Not at all Somewhat Likely

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.)

Please Circle		List Family Member (s)
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____

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Obesity yes/no _____

Obsessive Compulsive Behavior yes/no _____

Schizophrenia yes/no _____

Suicide Attempts yes/no _____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes If yes, what is your occupation?

_____

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

_____

_____

2. Do you consider spirituality or religion to be a resource in your life?

_____

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

_____

_____

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

_____

_____

5. Please describe your support system:

_____

_____

6. Why are you seeking therapy at this time?

_____

_____

7. Is there anything else you would like me to know?

_____