NEW PATIENT INTAKE FORM

Full Name: _____ Preferred Name: _____

Phone #: _____ Email: _____

Is it safe to contact you at the number above? _____

QUESTIONS

	Yes	No		Yes	No
Have you been in therapy before?	☐	☐	Are you committed to treatment?	☐	☐
Are you currently on medication?	☐	☐	Do you have any medical problems?	☐	☐
If so, list here:			Do you experience hallucinations?	☐	☐
			Are you sexually active?	☐	☐
Do you experience suicidal thoughts?	☐	☐	Do you have pets?	☐	☐
Do you have a known mental illness?	☐	☐	Have you been convicted of a crime?	☐	☐
If so, list here:			Are you in a relationship?	☐	☐
			Do you speak English fluently?	☐	☐

What are you hoping to achieve through therapy? _____

Do you have any concerns you would like me to know about? _____

I hereby certify that I have read this therapist's patient disclosure agreement as well as all other documents provided. I understand the contents of these documents and agree to the terms set forth therein.

Patient Signature: _____