PACIFIC ASSISTANCE GROUP

A PROFESSIONAL FAMILY THERAPY CORPORATION

INTAKE FORM

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

Please fill out this form and bring it to your first session or return it to the Area Administrator or Case Manager with whom you have been in contact.

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

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____)_____May we leave a message? □Yes □No

Cell/Other Phone: (_____)_____May we leave a message? □Yes □ No

Work/Other Phone: (_____)_____May we leave a message? □Yes □No

E-mail: _____May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: _____/_____/_____Age: _____ Gender: □ Male □ Female

Social Security: _____/_____/_____Ethnicity: _____

Are you currently employed? □ No □ Yes

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

_____

_____

PLEASE COMPLETE AND PROVIDE TO YOUR AREA ADMINISTRATOR

Employer: _____ (Name)
_____ (Address)
_____ (City/State/Zip)
Contact _____Telephone ( ) _____ - _____

Specialty / Board Certifications: _____
_____

Hospital: _____ (Name)
_____ (Address)
_____ (City/State/Zip)
Contact _____Telephone ( ) _____ - _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

On a scale of 1 to 10, how satisfied are you with your current relationships or status? ____

Please list any children/age: _____
_____
_____
_____

Referred by (if any): _____
May we contact this person to let him/her know you have called? □Yes □No

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

Please list: _____
_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____
_____

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.

_____

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? _____

_____

_____

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

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

10. If you are in recovery, please list your sober date: _____

11. Have you received treatment for alcohol or drug problems in the past? If so, please list previous treatment experiences and dates:

Treatment /Type	**Dates**

12. 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.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

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

If yes, describe your faith or belief:

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

_____

_____

_____

_____

15. What do you consider to be some of your weakness?

_____

_____

_____

_____

16. What would you like to accomplish out of your time in recovery support and monitoring?

_____

_____

_____

_____