NEW STEP COUNSELING
Ed Fitzpatrick, MSW, LICSW
329 South Sequim Ave., Ste. B
Sequim, WA 98382
360.808.4000

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.

Name: ______________________________ DATE: ______________

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

____

Birth Date: ____/_____/______ Age: _____ Gender: []Male []Female

Marital Status:

[]Never Married []Domestic Partner []Married

[]Separated []Divorced []Widowed

Please list any children/age:____

Address:____

Home Phone: (___)___________ May we leave a message? []Yes []No

Cell/Other Phone:(___)_________ May we leave a message? []Yes []No

Email:_________________________ May we email you? []Yes []No

*Please note that 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:_____________________________________

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Are you currently taking any prescription medications?
[ ]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 exercise?_________

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

____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
[ ]Yes
[ ]No
If yes, for approximately how long? _______________________________________

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
[ ]Yes
[ ]No
If yes, when did you begin experiencing this? ________________________________

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7. Are you currently experiencing chronic pain?
[ ]Yes
[ ]No
If yes, please describe:____

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

9. How often do you engage recreational drug use? (please circle)
Daily Weekly Monthly Infrequent Never

10. Are you currently in a romantic relationship?
[ ]Yes
[ ]No
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…)

	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	

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ADDITIONAL INFORMATION:

1. Are you currently employed?
   [ ]Yes
   [ ]No
   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?
   [ ]Yes
   [ ]No
If yes, describe your faith or belief?

____

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

____
____
____
____

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

____
____
____
____

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

____
____
____