New Day
Psychotherapy Group

Intake Form

Name: _____ Date: _____

Presenting Problems and Concerns

Describe the problem that brought you here today:

_____

_____

When did it start and how does it affect you:

_____

_____

Estimate the severity of the above problem: Mild - Moderate - Severe - Very Severe

Please check all of the behaviors and symptoms that you consider problematic:

__ Distractibility
__Hyperactivity
__Impulsivity
__Boredom
__Poor memory
__Phobias
__Compulsive behaviors
__Hopelessness
__Self-harm behaviors
__Guilt/Shame
__Eating problems
__Computer addiction
__Parenting problems
__Homicidal thoughts
__Relationship problems
__Visual hallucinations
__Change in appetite
__Lack of motivation
__Isolation
__Anxiety/Worry
__Panic attacks
__Obsessive thoughts
__Sadness/Depression
__Helplessness
__Loneliness
__Fatigue
__Gambling problems
__Problems with pornography
__Frequent arguments
__Flashbacks
__Work/School problems
__Other _____
__Paranoia
__Racing thoughts
__Too much energy
__Mood Swings
__Social discomfort
__Sleep problems
__Loss of pleasure
__Thoughts of death
__Low self-esteem
__Nightmares
__Aggression/Fights
__Sexual Problems
__Irritability/Anger
__Alcohol/Drug use
__Hearing voices

Are your problems affecting any of the following?

__Work/School
__Hygiene
__Finances
__Health
__Self-esteem
__Housing
__Recreational activities
__Everyday tasks/functioning
__Relationships
__Legal matters
__Sexual activity

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Have you ever had thoughts, made statements, or attempted to hurt yourself? __YES ___NO If yes, please describe:

_____

Have you ever had thoughts, made statements, or attempted to hurt someone else? __YES ___ NO If yes, please describe:

_____

Family and Developmental History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/Partner			
Children			

Family Mental Health Problems	Who?
Depression	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Eating Disorders/Disordered Eating	
Hyperactivity	
Sexually Abused	
Bipolar	
Anger/Abusive	
Alcohol Abuse	
Substance Abuse	

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Schizophrenia	
Completed Suicide	
Psychiatric Hospitalizations	

__Parents legally married or living together
__Parents temporarily separated
__Mother remarried: # of times __
__Father remarried: # of times __

Please check if you have experienced any of the following types of trauma or loss:

__Emotional abuse
__Sexual abuse
__Physical abuse
__Parent substance abuse
__Financial problems
__Neglect
__Violence in the home
__Crime victim
__Parent illness
__Lived in a foster home
__Multiple family homes
__Homelessness
__Loss of a loved one

Past/Present Psychotherapy (specify: month years (beginning to end), estimated number of sessions, initial reason for therapy and how helpful it was and why it ended:

1)_____
_____
_____
_____
_____

2)_____
_____
_____
_____
_____

3)_____
_____
_____
_____
_____

Medical Information

Name of Primary Care Physician: _____
Date of last physical exam: _____
Have you experienced any of the following medical conditions during your lifetime?

__Allergies __Asthma __Headaches __Stomach aches
__Chronic pain __Surgery __Serious accident __Head injury
__Dizziness/fainting __Meningitis __Seizures __Vision problems

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__High fevers __Diabetes __Hearing problems __Miscarriage
__STDs __Abortion __Sleep disorders __Other _____

Please list any CURRENT health concerns: _____

Current prescription medications: ___None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter mediations (including vitamins, herbal remedies, etc.):
_____
_____

Allergies and/or adverse reactions to medication: __None
If yes, please list: _____

Substance Use History

Substance Type	Current Use (last 6 mos.)				Past Use			
	Y	N	Freq	Amount	Y	N	Freq	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
LSD								
PCP								
Steroids								
Benzodiazepines								

Have you had withdrawal symptoms when trying to stop using any substances?
__YES __NO If yes, please describe:
_____
_____

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Have you ever had problems with work, relationships, health, the law, etc., due to your substance use? __YES __NO If yes, please describe:
_____
_____

Interpersonal/Social/Cultural Information

Please describe your social support network (check all that apply):
__Family __Neighbors __Friends __Co-workers __Community Group __Religious/Spiritual Center

To which cultural or ethnic group do you belong? _____

How important are spiritual matters to you? __Not at all __Little __Somewhat __Very much

Describe any special areas of interest or hobbies:
_____
_____
_____

Additional Information

Employment
Employer: _____ Position: _____
Stress level of this position: __Low __Medium __High

Education
Are you currently attending school? __Yes __No
__High School Graduate? __GED Year_____
College Degree _____ Year _____ Major _____

Military Service
Have you been/are you currently in the military? __Yes __No
Branch _____ Date of Discharge _____
Type of Discharge_____ Rank _____

Were you in combat? __Yes __No

Legal
Have you ever been convicted of a misdemeanor or felony? __Yes __No If yes, please explain_____

Are you currently involved in any divorce or child custody proceedings? __Yes __No

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_____
_____

What gives you the most joy or pleasure in your life?

_____
_____
_____

What are your most important hopes or dreams?

_____
_____
_____

Additional Comments:

_____
_____
_____
_____
_____
_____

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