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Finding the Balance
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Intake Questions

Name:_____ Date of Birth_____

Address:_____

City_____ Zip_____ Phone_____

Occupation_____ Gender_____

Email_____ Emergency Contact_____

What is your current living situation? (partners, children, spouses, roommates, extended family, pets)_____

_____

_____

What is your initial complaint or concern? _____

_____

_____

_____

When did this problem/ concern start? _____

_____

_____

Please give a brief history of the problem/ complaint._____

_____

_____

_____

Did you seek therapy (previous to now) for this problem/ complaint and if yes give a brief description, date and what was helpful or not._____

_____

_____

_____

Please check if you have any of these symptoms:

____sleep problems ____eating _____concentration difficulties _____loneliness

_____moody ____sad ____angry ____irritable ____anxious ____hopelessness

____panic attacks ____cycling repetitive thoughts ____recurring bad dreams

____weight changes ____unhealthy or self-harming behaviors

____suicidal thoughts ____decrease in ability to enjoy typical pleasurable activities

____increase in physical discomfort/ pain

____changes in relationships w/ family, friends, work.

Are you being treated for a medical condition/ concern?_____

_____

_____

Please list the medication both prescribed, over the counter and herbal.

Medication/ Condition	Amount	Prescribed by
1._____		
2._____		
3._____		
4._____		
5._____		

What are your current sources of rejuvenation, relaxation and play? _____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

Is there any other information that would be of value to me in helping you? _____

_____

_____

_____

_____

_____