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## Intake Form

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:
□ Medical Provider:
_____
□ Insurance Provider:
_____
□ Website at http://www.drlipori.com
□ Psychology Today website
□ Friend/Family:
_____

Have you previously received any type of mental health services? □ No □ Yes

If yes, which of the following:

□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization

Please provide:

Name of provider or facility:
_____

Location:
_____

Dates of treatment:
_____
Reason for treatment:
_____

Briefly, what brings you in today?

When did your problem first start? Within the last:
□ 30 days □ 6-12 months □ 2 years □ During adolescence □ During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

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

## Family History

Where were you born?

_____

Where did you grow up?

_____

□ city □ suburbs □ country

Please list your parents and siblings. Please use additional space on the back if needed.

| Name | Age | Relationship | Where do they now live? | If deceased, age and cause of death |
|---|---|---|---|---|
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Who did you live with, growing up?

_____

Mother's occupation:

_____

Father's occupation:

_____

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.).

| Condition | Please circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Sexual Abuse | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |
| Obsessive Compulsive Behavior | yes/no | |
| Schizophrenia | yes/no | |
| Suicide Attempts | yes/no | |
| Other diagnosed mental | yes/no : which was--- | |

| | | |
|---|---|---|
| health condition? | | |

Marital Status:
□ Never Married
□ Domestic Partner □ Married

For how long?_____

Please give partners name: _____

On a scale of 1-10 (best), how would you rate your relationship? _____

□ Separated □ Divorced □ Widowed

If widowed, please give partners name, and year deceased:
_____

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Please list any children, their names, and ages:

| Name | Age | Name of other parent | If deceased, age and cause of death |
|---|---|---|---|
| | | | |
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## Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or

provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

| Medication/Supplement | Dosage | Condition | Began/Stopped |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Prescribing provider and contact information:
Name:
_____

Specialty:
_____

Facility:
_____

Phone, email, or Fax:
_____

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:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep: staying asleep awakening early sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise to you participate in?

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

_____

Any change in weight over the past year? □ No □ Yes:
_____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe
_____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

**Additional Information**

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

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

If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?