Kevin Spath Counseling Service
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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 www.kevinspath.com
- Psychology Today website
- Friend/Family: ____

Have you previously received any type of **mental health services?** (please circle)
No Yes

If yes, which of the following: (**please circle**)
psychotherapy outpatient hospitalizations inpatient hospitalization medication

Name of provider or facility: ____

Location: ____

Dates of treatment: ____

Reason for treatment: ____

Briefly, what brings you in today? ____

____

When did your problem **first start?** (**please circle**)

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?**
____

Type of neighborhood: (**please circle**) city suburbs country other

Please list your **parents and siblings:**(Please use additional space on the back if needed.)

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

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, **or yourself**, in the space provided (father, grandmother, uncle, etc.).

Condition	Please Circle	List Family Member(s) / Self
Anxiety	Yes / No	
Alcohol / Substance Abuse	Yes / No	
Bipolar Disorder	Yes / No	
Body Image Issues	Yes / No	
Conflict at Work	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorders	Yes / No	
Excessive Gaming / Electronics	Yes / No	
Gambling Addiction	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Post Traumatic Stress Disorder	Yes / No	
Self-Harm	Yes / No	
Sexual Abuse	Yes / No	
Sexual Acting Out	Yes / No	
Suicide Thoughts / Attempts	Yes / No	
Trouble Managing Money	Yes / No	
Other Diagnosed Mental Health Condition	Yes / No	

Relationship Status (**please circle**):

Never Married   Separated   Divorced   Domestic Partner   Married   Widowed

For how long _______ Please give partners name. ______________________________

If widowed, please give partners name, and year deceased.
____

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

Are you currently in a **romantic relationship**?
- No
- Yes **If yes**, for how long, and with whom? ______________________________

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

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? (**please circle**) No Yes

Are you currently experiencing any **chronic pain**? (**please circle**) 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 if different.

____

Additional Information

What do you **enjoy about your work** (full-time homemaker included)?

____

If you are 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**? (**please circle**) 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 weaknesses**? ____________________________

____