

Margo Steinfeld, LCSW, MA, CGP
Center for Relational Therapy
Park Slope, Brooklyn, New York
www.margosteinfeld.com
718-783-5066

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:

_____ (Last) (First) (Middle Initial)

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

_____ (Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Marital Status:

- Never Married Domestic Partnership Married Separated
 Divorced Widowed

Please list any children/age:

Address:

_____ (Street and Number)

_____ (City) (State) (Zip)

Home Phone: (_____) _____ May we leave a message?
 Yes No

Cell/Other Phone: (_____) _____ May we leave a message?
 Yes No

E-mail: _____ May we email you?

Yes No

*Please note: 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:

Are you currently taking any prescription medication?

- 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 generally exercise? _____

What types of exercise do you participate in:

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

5. Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

- No
- Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe? _____

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

9. How often do you engage recreational drug use?

- Daily Weekly Monthly Infrequently Never

10. 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? _____

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	

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

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? No Yes

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 weakness?

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