Susan Hameline-Kasznay LMFT - Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected and confidential information.

Please fill out this form and bring it to your first session.

Name:_______(Last) (Middle) __________ (First)

Name of Parent Guardian (if under 18 years):

______________________________ __________
(Last) (Middle) (First)

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
May we text you Yes / No

Email: _____ ____________________________ May we Email you Yes / No
*Please note: Email correspondence is not considered to be confidential medium of communication

Referred by (if any)____

Family Mental Health History:

In the section below identify if there is a family history of any of 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 Disorder	Yes No	
Obesity	Yes No	
Obsessive Compulsive Behavior	Yes No	
Schizophrenia	Yes No	
Suicide Attempts	Yes No	

Additional Information:

1. Are you currently employed? Yes No

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 religion Yes No

If yes, please 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 weaknesses?

____

5. What would you like to accomplish in therapy?

____

Have you previously received-any type of mental health services (psychotherapy, psychiatric services, etc.)? No Yes

If yes, previous therapist/practioner: ______________________________________

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 and prescriber:_

____

General Health and Mental Health Information

1. How would you rate your current physical health? (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?

   Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep issues you are 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 appetite or eating patterns

____

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

If yes, for proximately how long? ______________________________

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

If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain? Yes No
If yes for how long?

____

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

9. How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? Yes No

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?

____

____

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