kirsten bailey erickson, licsw

integrative psychotherapist 206.200.1093

2743 California Ave., SW, Suite 301

Seattle, WA 98116

INTAKE FORM

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

Name: ____

(Last) (First) (Middle Initial)

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

____

(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: ____

Address: ____

(Street and Number)

____

(City) (State) (Zip)

Home Phone: ( ) Cell/Other Phone: ( )

May we leave a message at either of these numbers? □ Yes □ No

E-mail: ____

May we email you? □ Yes □ No

Please note: Email correspondence is not considered to be a confidential medium of

communication.

Insurance______________________________

Insured Name__________________________ Insured Date of Birth____________

ID number________________________ Insured Employer______________________

Group Number____________________ Insurance Phone Number________________

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

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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 to 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? _______________________________

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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? __________________

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, check the box and then please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse	□	____________________
Anxiety	□	____________________
Depression	□	____________________
Domestic Violence	□	____________________
Eating Disorders	□	____________________
Obesity	□	____________________
Obsessive Compulsive Behavior	□	____________________
Schizophrenia	□	____________________

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Bipolar Disorder	☐	________________
Suicide Attempts	☐	________________

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation?

____

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 weaknesses?

____
____
____
____

5. How will you know when therapy is completed?

____
____
____
____