INTAKE FORM
The Leggett Group

Today's Date:_____

Name: _____

Birth Date: _____ /_____ /_____ Age: _____

Address: _____

_____

Home Phone:_____May we leave a message here? □ Yes □ No

Cell/Other Phone: _____May we leave a message here? □ Yes □ No

Referred by/ how you found out about us:
_____

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?
□ No
□ Yes Please list: _____
_____

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 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? _____

7. Are you currently experiencing any chronic pain?

□ No □ Yes

If yes, please describe: _____

8. Do you use alcohol?_____ If so, how often?_____

9. Do you engage in recreational drug use?_____
If so, how often, and which drug? _____

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 (e.g. father, maternal 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	
Obsessive Compulsive Behavior	yes/no	
Major mental illness	yes/no	
Suicide Attempts or hospitalizations	yes/no	

Other (please describe)_____

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 weaknesses?

_____
_____
_____
_____

5. Overall, how well do you feel you take care of yourself?

_____
_____
_____

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

_____
_____
_____

Thank you!