SOLSTICE
MENTAL HEALTH TREATMENT

INTAKE FORM

Please provide the following information and answer the questions below. The information you provide here is protected as confidential information. Please return this completed form, along with a photo of your driver's license, by emailing it to ***solsticemht@gmail.com****.*

Legal Name:_____
(Last) (First) (Middle Initial)

Preferred Name: _____

Name of Parent or Guardian if under 18 years of age:

_____
(Last) (First) (Middle Initial)

Birth Date:_____/_____/_____ Age: _____ Gender: _____

Marital Status:

□ Never Married □ Domestic Partnership/s □ Married □ Separated

□ Divorced □ Widowed

Please list any children/ages:_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Cell Phone: _____ May we leave a message? □Yes □No

Other Phone:_____ May we leave a message? □Yes □No

Email: _____May we email you? □Yes □No

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

Emergency Contact Name & Phone Number (this person may be contacted in the event your therapist is concerned for your well being or safety):

_____

SOLSTICE
MENTAL HEALTH TREATMENT

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 admitted to a hospital or treatment center for inpatient psychiatric treatment?

□ 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 to you participate in: _____

SOLSTICE
MENTAL HEALTH TREATMENT

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. How often do you drink alcohol? □ Never □ Weekly □ Daily □ Socially/Occasionally

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

10. Are you currently in a romantic relationship/s? □ 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:

_____

_____

_____

12. What brought you to therapy? _____

_____

_____

SOLSTICE
MENTAL HEALTH TREATMENT

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	
Bipolar	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:

_____

SOLSTICE
MENTAL HEALTH TREATMENT

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

_____

_____

_____

_____

4. Do you consider yourself financially stable?

_____

_____