Treatment Intake Form

Please complete all information on this form and bring it to your first visit or scan and e-mail the completed form to me at drsallyvalentine@me.com. Couples should each complete a form. If I do not have a completed form for your first visit, we will need to complete it at that time.

Name ____ Date ________________________

Age ______________________________________ Date of Birth ___________________

What are the problem(s) for which you are seeking help?
1. ____
2. ____
3. ____

What do you hope to get out of therapy?
1. ____
2. ____
3. ____

Who referred you? ____

Medical history
Please check all that apply.

( ) Thyroid disease
( ) Anemia
( ) Liver disease
( ) Chronic fatigue
( ) Kidney disease
( ) Diabetes
( ) Erectile dysfunction
( ) Delayed ejaculation
( ) Premature ejaculation
( ) Asthma or respiratory problems
( ) Stomach or intestinal problems
( ) Fibromyalgia
( ) Heart disease
( ) Epilepsy or seizures
( ) Chronic pain
( ) High cholesterol
( ) High blood pressure
( ) Head trauma
( ) Liver problems
( ) Cancer (type) ________
( ) Injury or trauma to genitals
( ) Endometriosis
( ) Transgender surgery
( ) Sexually transmitted diseases
( ) Skin problems
( ) Weight loss or gain
( ) Other
____
____

Allergies__________________________ Current weight ___________ Height __________

Primary care provider name ____
Date and place of last physical exam: _______________________________________

For women only
Date of last menstrual period ________
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No
Are you planning to get pregnant again? ( ) Yes ( ) No
Birth control method ___________________________
How many times have you been pregnant? ________ How many live births? ________

List all current **prescription medications**, their dosage and frequency, and what you take them for. If you take more than five, please list the rest on a separate sheet.

Name	Dosage	Frequency	Purpose

List all current **over the counter medications and supplements**, their dosage and frequency, and what you take them for. If you take more than five, please list the rest on a separate sheet.

Name	Dosage	Frequency	Purpose

Emotional or behavioral issues

Please check all that apply.

( ) Depressed mood
( ) Racing thoughts
( ) Excessive worry
( ) Unable to enjoy activities
( ) Impulsivity
( ) Anxiety attacks
( ) Sleep disturbance
( ) Increased risky behavior
( ) Avoidance
( ) Increased libido
( ) Hallucinations
( ) Difficulty concentrating
( ) Forgetfulness
( ) Decreased need for sleep
( ) Suspiciousness
( ) Change in appetite
( ) Excessive energy
( ) Excessive guilt
( ) Increased irritability
( ) Fatigue
( ) Crying spells
( ) Decreased libido

Suicide risk assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No
If yes, please answer the following questions. (If no, please skip to the next section.)
Do you currently feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts?____
Have you thought about how you would kill yourself? ( ) Yes ( ) No
Have you ever tried to kill or harm yourself before? ( ) Yes ( ) No
Do you have access to guns? ( ) Yes ( ) No
If yes, please explain. ____

Past mental health treatment
Outpatient treatment ( ) Yes ( ) No
If yes, please describe when, by whom, and for what you were being treated.______________
____
____
Psychiatric hospitalization ( ) Yes ( ) No
If yes, describe for what reason, when and where. _____________________________________
____

Exercise level
Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? ____________
What kind of exercise do you do? ____

Drug and alcohol use
How many days per week do you drink any alcohol? ____________
What is the least number of drinks you will drink in a day? _______
What is the most number of drinks you will drink in a day? _______
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? ______
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? ____
____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? ____
____
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances, where and when? _______________________________________

____

Trauma history
Do you have a history of neglect or emotional, sexual, or physical abuse? ( ) Yes ( ) No
If yes, please describe when, where and by whom: ______________________________
____

Education and work history

What is your highest educational level or degree attained? _________________________
Are you currently: ( ) working ( ) student ( ) unemployed ( ) disabled ( ) retired
How long in present position? ____
What is/was your occupation? ____
Where do you work? ____

Relationship history

Are you currently: ( ) married ( ) partnered ( ) divorced ( ) single ( ) widowed ( ) polyamorous
How long? __________
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation:

( ) heterosexual
( ) lesbian
( ) gay
( ) bisexual
( ) transgender MtF
( ) transgender FtM
( ) unsure/questioning
( ) asexual
( ) other (type) ________
( ) prefer not to answer

What is your spouse or significant other's occupation? ____________________________
Describe your relationship with your spouse or significant other: ___________________
____
____
____
Have you had any significant prior relationships? ( ) Yes ( ) No
If yes, how many? ______________ How long? _______________________________
Do you have children? ( ) Yes ( ) No
If yes, list ages and gender: ____
____
Describe your relationship with your children: _________________________________
____
____
____
List everyone who currently lives with you:
____
____

Legal history

Have you ever been arrested? ( ) Yes ( ) No
If yes, what were you arrested for? ____
Do you have any pending legal problems? ( ) Yes ( ) No
If yes, what are they? ____

Spirituality

Do you belong to a religion or spiritual group? ( ) Yes ( ) No
If yes, which one and what is your level of involvement? ____________________________
____

Is there anything else that you would like me to know about you? _______

____
____
____
____
____
____

Signature____Date______________

Confidential Client Information

Name:______________________________ Date:______________________

Address:____

____

Home Phone :(____)______________________ Work :(_____)__________

Mobile :(______)____

E-Mail: ____

Age______________________________ Date of Birth:_______________

Present Employer:____

Reason for Visit:

____

Name of Spouse/ Significant Other: _______________________________

Primary Physician: ____

Current Medications:

____

Allergies: ____

Previous Therapy_____________ Yes ____________________________ No _____

Referred By: ____

Emergency Contact:____

Relationship: ____

Phone :(______)____

Please note: Each appointment time is reserved for you. Failure to provide 24hrs notice of cancellation will result in full charge for the appointment.

____

Signature