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INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office. Thank you for taking the time to provide me with the information that will help me address your concerns.

Today's Date _____ Referred by: _____

Current reason for seeking therapy: _____

Name: _____ Birth Date: ____/____/____/

Age: _____ Gender: Male Female

Marital Status: Never Married Partnered Married Separated Divorced Widowed

Address with zipcode: _____

Home Phone: () _____ Cell phone () _____ Work Phone: () _____

Give my permission to be called at: HOME Yes/No _____ CELL/ Yes/No _____ WORK Yes/No _____

Special Instructions: _____

I understand that if I have caller ID, the counselors name will be disclosed to others. Please Initial _____

E-mail: _____ May we email you? Yes No

*Please be aware that email might not be confidential.

Emergency Contact : Name _____

Phone _____ -Relationship to you _____
-

If married, how long? _____

Date of previous marriages if any _____

Number of Children: _____ Ages: _____

Education; Highest year of schooling completed _____

Please check the areas that are problems or concerns for you:

- Family/Children _____
- Marital Relationship _____
- Other Relationships _____
- Employment _____
- Finances _____
- Living Situation _____
- School _____
- Legal Problems _____
- Other (Specify) _____

Symptom/Problems List

Circle any item that has been a concern or problem and indicate how long.

- | | | |
|--|---|-------------------------|
| Sleep Problems | Premenstrual or Menopausal Issues | Low self esteem |
| Fatigue/loss of energy | Over eating or bingeing or excessive weight gain? | Suicidal Thoughts/Plans |
| Headaches | Under eating, underweight excessive weight loss? | Excessive Worry |
| Nausea, diarrhea or other digestive distress | Depressed mood | Irritability |
| Dizziness or faintness | Loneliness | Fears including Phobias |
| Shortness of breath | Frequent Crying | Social fears (shyness) |
| Trembling or shaking | Mood Swings | Guilty feelings |
| Trouble swallowing/"lump in throat" | Feeling of helplessness and hopelessness | Isolation |
| Palpitations/accelerated heart rate | Lack of interest in most activities | Lack of assertiveness |
| Nightmares/Frightening Dreams | | Aggressive behavior |
| | | Perfectionism |
| | | Memory problems |

Difficulty concentrating

Racing thoughts
Hallucinations
Homicidal Thoughts

Suicide Attempt

Have you ever been abused?

Physically Yes ___ No ___ Not Sure _____

Emotionally Yes ___ No ___ Not Sure _____

Sexually -Yes ___ No ___ Not Sure _____

Have you had previous psychotherapy? No Yes

Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes No if yes, please list: _____

Are you currently taking supplements/vitamins etc? Please list _____

If no, have you been previously prescribed psychiatric medication? Please list _____

Have you ever been hospitalized for mental health reasons? Yes No

If yes where? _____

When/Dates _____

Who is your current Primary Physician? _____

Phone number and Address _____

Date of last physical exam _____

Significant operations and illnesses _____

Are you currently or have you had alternative therapies? (ie. Acupuncture, body work, homeopathy, naturopathic medicine etc) Please list _____

Do you regularly use alcohol? No Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

Do you ever feel you are drinking excessively?

Do others see your drinking as a problem?

Have you had blackouts after drinking?

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely N/A

In the last year, have you experienced any significant life changes or stressors?

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

SEXUAL HEALTH HISTORY:

Are any of your current concerns related to your sexuality? No Yes

If yes, what are your concerns? _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that applies and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty

Depression	yes/no	Alcohol/Substance Abuse	yes/no
Bipolar Disorder	yes/no	Eating Disorders	yes/no
Anxiety Disorders	yes/no	Learning Disabilities	yes/no
Panic Attacks	yes/no	Trauma History	yes/no
Schizophrenia	yes/no	Suicide Attempts	yes/no

Strengths /Resources

What gives your life meaning? _____

What or whom do you have faith in? _____

Do you pray or meditate? _____

What or who do you hold to be sacred in your life? _____

Do you have a spiritual community? _____

What do you do to nourish yourself? _____

What do you consider to be your strengths? _____

What do you like most about yourself? _____

What are effective coping strategies that you've learned? _____

What are your goals for therapy? _____
