INTAKE INFORMATION

Full Name_____ Date:_____

Date of Birth _____ Age____

Circle any of the following that apply to you:

Severe Headaches	*Appetite Change*	*Problems Sleeping*
Head Injury	*Seizures*	*Legal Trouble*
Alcohol Misuse	*Drug Abuse*	*Superstitions*
Anxiety	*Depression*	*Attention Problems*
Work Problems	*Home Problems*	*High Blood Pressure*
Diabetes	*Hyperthyroidism*	*Hypothyroidism*

Have you ever felt suicidal? YES NO

Are you prescribed medication for psychological problems?

YES NO **If yes, by whom?** _____

Have you been hospitalized for psychological problems?

YES NO **If yes, what year(s)?** _____

Is there any history of mental illness in your family?

YES NO **If yes, give details here:**

Did anyone refer you here? YES NO **If yes, who?**

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