New Day
Psychotherapy Group

Intake Form

Name: ____ Date: ____________________

Presenting Problems and Concerns

Describe the problem that brought you here today:

____

____

When did it start and how does it affect you:

____

____

Estimate the severity of the above problem: Mild - Moderate - Severe - Very Severe

Please check all of the behaviors and symptoms that you consider problematic:

__ Distractibility	__Change in appetite	__Paranoia
__Hyperactivity	__Lack of motivation	__Racing thoughts
__Impulsivity	__Isolation	__Too much energy
__Boredom	__Anxiety/Worry	__Mood Swings
__Poor memory	__Panic attacks	__Social discomfort
__Phobias	__Obsessive thoughts	__Sleep problems
__Compulsive behaviors	__Sadness/Depression	__Loss of pleasure
__Hopelessness	__Helplessness	__Thoughts of death
__Self-harm behaviors	__Loneliness	__Low self-esteem
__Guilt/Shame	__Fatigue	__Nightmares
__Eating problems	__Gambling problems	__Aggression/Fights
__Computer addiction	__Problems with pornography	__Sexual Problems
__Parenting problems	__Frequent arguments	__Irritability/Anger
__Homicidal thoughts	__Flashbacks	__Alcohol/Drug use
__Relationship problems	__Work/School problems	__Hearing voices
__Visual hallucinations	__Other ________________________	

Are your problems affecting any of the following?

__Work/School	__Self-esteem	__Relationships
__Hygiene	__Housing	__Legal matters
__Finances	__Recreational activities	__Sexual activity
__Health	__Everyday tasks/functioning	

Have you ever had thoughts, made statements, or attempted to hurt yourself? __YES
___NO If yes, please describe:

____

Have you ever had thoughts, made statements, or attempted to hurt someone else?
__YES ___ NO If yes, please describe:

____

Family and Developmental History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/Partner			
Children			

Family Mental Health Problems	Who?
Depression	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Eating Disorders/Disordered Eating	
Hyperactivity	
Sexually Abused	
Bipolar	
Anger/Abusive	
Alcohol Abuse	
Substance Abuse	

Schizophrenia	
Completed Suicide	
Psychiatric Hospitalizations	

__Parents legally married or living together
__Parents temporarily separated

__Mother remarried: # of times __
__Father remarried: # of times __

Please check if you have experienced any of the following types of trauma or loss:

__Emotional abuse
__Sexual abuse
__Physical abuse
__Parent substance abuse
__Financial problems
__Neglect
__Violence in the home
__Crime victim
__Parent illness
__Lived in a foster home
__Multiple family homes
__Homelessness
__Loss of a loved one

Past/Present Psychotherapy (specify: month years (beginning to end), estimated number of sessions, initial reason for therapy and how helpful it was and why it ended:

1)____
____
____
____
____

2)____
____
____
____
____

3)____
____
____
____
____

Medical Information

Name of Primary Care Physician: ____
Date of last physical exam: ____
Have you experienced any of the following medical conditions during your lifetime?

__Allergies
__Chronic pain
__Dizziness/fainting
__Asthma
__Surgery
__Meningitis
__Headaches
__Serious accident
__Seizures
__Stomach aches
__Head injury
__Vision problems

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__High fevers __Diabetes __Hearing problems __Miscarriage
__STDs __Abortion __Sleep disorders __Other ____________

Please list any CURRENT health concerns: ____

Current prescription medications: ___None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter mediations (including vitamins, herbal remedies, etc.):
____
____

Allergies and/or adverse reactions to medication: __None
If yes, please list: ____

Substance Use History

Substance Type	Current Use (last 6 mos.)				Past Use			
	Y	N	Freq	Amount	Y	N	Freq	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
LSD								
PCP								
Steroids								
Benzodiazepines								

Have you had withdrawal symptoms when trying to stop using any substances?
__YES __NO If yes, please describe:
____
____

Have you ever had problems with work, relationships, health, the law, etc., due to your substance use? __YES __NO If yes, please describe:

____

____

Interpersonal/Social/Cultural Information

Please describe your social support network (check all that apply):
__Family __Neighbors __Friends __Co-workers __Community Group
__Religious/Spiritual Center

To which cultural or ethnic group do you belong? ______________________________

How important are spiritual matters to you? __Not at all __Little
__Somewhat __Very much

Describe any special areas of interest or hobbies:

____

____

____

Additional Information

Employment
Employer: ________________________________ Position: ________________________
Stress level of this position: __Low __Medium __High

Education
Are you currently attending school? __Yes __No
__High School Graduate? __GED Year_________
College Degree _________________________ Year ______ Major _________________

Military Service
Have you been/are you currently in the military? __Yes __No
Branch _______________ Date of Discharge ______________
Type of Discharge____________ Rank _________________

Were you in combat? __Yes __No

Legal
Have you ever been convicted of a misdemeanor or felony? __Yes __No If yes, please explain____

Are you currently involved in any divorce or child custody proceedings? __Yes __No

____

____

What gives you the most joy or pleasure in your life?

____

____

____

What are your most important hopes or dreams?

____

____

____

Additional Comments:

____

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