E.M. Goldman Clinical Group
Integrative Therapy Services

INTAKE FORM

Please fill out this form, it will help us in our work together. All information is confidential as outlined in our Office Policy Form. Please return this and other paperwork to your second session. Thank you!

Name: **Date:**

Current Address:

Phone: **Email:**

Birth date and Location:

Referral Source:

Occupation:

Presenting Problem: (Please be specific, when did it start, how does it affect you, what have you tried to do to address this issue?)

How severe is this problem? (mild, moderate, severe)
Who do you live with:

Relationship to you:

Name:

Years:

Past and Present relationships: (years together? Partner's name? Nature of the relationship)

Children: (if there are any children that you are close to, names, ages, nature of the relationship)

Parents: (Name, age, or year & cause of death, how did they treat you? Statement about the relationship)
Father(s)

Mother(s)

Step-parents? Grandparents? Primary care takers?

Siblings: (name, age or cause of death, statement about the relationship)

Medical Doctors: (names and numbers)

Specify all medications you are currently taking:

Past/Present drug or alcohol use, abuse or dependence:

Sleep: (how do you sleep? Regular hours, feel upon waking)

Food: (do you consider yourself a healthy eater?)

Exercise habits:

Suicide attempts or violent behavior (age, describe reasons or circumstances)

Past Psychotherapy (what was helpful, what was not, why did you stop and how was it ended?)

Describe your childhood: (friendships, activities, relocations, primary school, middle school, high school, college?)

What gives you joy in life now:

Main worries or fears:

Most important hopes and dreams:

Any other important information that we need to best help you