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INTAKE HISTORY FORM

Name ____
Address ____
Cell Phone_________________________________ Other Phone ______________________
Birthdate: ________________________________
Presumptive Dxs: ____
____
Have you ever been hospitalized? ____
Have you had any previous counseling/psychotherapy? ___________________________

- ☐ If yes, please describe type and duration: ___________________________________
  ____

Are you currently in therapy: ____

- ☐ Name and phone number of provider: ____
  ____
- ☐ Do you wish us or feel comfortable with us contacting your therapist? ___________
  ____
- ☐ If yes, please sign our release of information form.

Is there any significant family history of specific illness, medical condition or mental disorder?

- ☐ Yes or no ____
  ____
  ____

Usual Amount of Sleep/Night: ____

MEDICAL HISTORY

Check if applicable **Rate on Scale if applicable** **Explanation**

☐ PMS - Point in Menstrual Cycle: ______________________________	☐ Thyroid issues; ___
	☐ Allergies;___
☐ Strokes; ___	☐ Tinnitus; ___
☐ Heart Attacks; ___	☐ IBS; ___
☐ Pulmonary; ___	☐ Viral Illness; ___
☐ Endocrine; ___	☐ Balance problems; ___
☐ GI; ___	☐ Incontinence; ___
☐ Polio; ___	☐ Swallowing Problems;___

☐ HIV;___ ☐ Vascular; ___ ☐ Chronic Ear Infections/Ear Tubes; ___ ☐ Infections/Viruses/High Fever; ___ ☐ Visual; ___ ☐ Lupus;___ ☐ Metabolic Disorders; ___ ☐ Chemical Sensitivities; ___	☐ Liver; ___ ☐ Do you eat fish, meat, or fowl? ___ ☐ Use Artificial Sweeteners/diet drinks? ___ ☐ Menopausal; ___ ☐ Chronic Pain:________ 0-10:______

Exposure to Toxic Agents (e.g., significant exposure to heavy metals, insecticides, carbon monoxide, solvents, drug overdoses, chemotherapy or radiation, etc.): ____________________
____
____

Odd/Unusual Symptoms (describe here)
____
____
____

Check if applicable **Rate on Scale (0-10)** **Explanation**

Perinatal:

- ☐ Prenatal stress or injury ____
- ☐ Prenatal drug exposure ____
- ☐ Length of labor ____
- ☐ Birth weight ____
- ☐ Birth trauma (fetal distress/forceps/breech/induced) ______________________
  ____
- ☐ Anesthesia ____
- ☐ Anoxia ____
- ☐ Premature/late delivery ____
- ☐ Adopted at age ____
- ☐ Medical problems after birth ____
- ☐ While pregnant with you, did your mother
  - smoke cigarettes? ____
  - use alcohol or drugs? ____
  - experience physical abuse? ____

Growth & Development:

- ☐ Motor coordination ____
- ☐ Infections/allergies ____
- ☐ Emotional development ____
- ☐ Developmental delay ____
- ☐ Handedness ____

- ☐ Language/speech/writing problems (0-10) ______________________________________
  ____
- ☐ Reading Problems ____
- ☐ Math Problems (0-10) ____
- ☐ School:
  - Easy (favorite) subjects ____
  - Hard (boring subjects ______________________________________
  - Below grade ____
  - Special Classes ____
  - Learning Disability ____
  - Behavior/Discipline Problem ______________________________
  - Concentration Problems (0-10:) ____________________________
  - Disorganized (0-10:) _____________________________________
  - Forgetful (0-10:) ____
  - Impulsive (0-10:) ____
  - Sequential vs. spatial skills ______________________________
  - Hyperactive (0-10:) ____________________________________
  - ADD (# of Criteria met ____________) or ADHD (# of criteria met______)
  - Work completion ____
  - Academic Strengths:
    - High School GPA: ____
    - College GPA: ____

Neurological:

- ☐ Skull/Head Surgeries/Deformities _________________________________
- ☐ Head injury - Blows to the Head, Concussions, or Head Injuries (football, boxing, soccer, skateboarding, lacrosse, skiing, hockey, horseback riding; "see stars") _______________
  ____
- ☐ Loss of Consciousness? ____
- ☐ Total Number of Head Injuries _____________________________________
- ☐ Neurological Disease ____
- ☐ Memory Difficulties (0-10:) ______________________________________
- ☐ Headaches ____
- ☐ Concentration ____
- ☐ Seizures ____
- ☐ Confusion ____
- ☐ Restless Leg ____
- ☐ Apnea or daytime drowsiness _____________________________________
- ☐ Fatigue (0-10:) ____
- ☐ Headaches or Migraines (0-10:) __________________________________
- ☐ ECT ____
- ☐ Accidents ____
- ☐ Incoordination ____
- ☐ Tics/Twitches, Tremor, or Parkinson's _______________________________
- ☐ Weakness ____

- ☐ Accident prone ____
- ☐ Sensory Impairments ____
- ☐ Lyme ____
- ☐ Fibromyalgia ____
- ☐ # of Anesthetics ____
- ☐ Sensitivity to Light & Sound ___________________________________
- ☐ Anosmia ____
- ☐ Oversensitive Smell _______________________________________

Attention and Organization:

- ☐ Attention span problem ____
- ☐ Distractibility ____
- ☐ Impulsivity ____
- ☐ Organizational ability ___________________________________

Mental/Behavior/Emotions:

- ☐ Mood swings ____
- ☐ Depression (0-10:) ____
- ☐ Suicide Attempts? ____
- ☐ Bi-Polar/Mood Swings (0-10:)_____________________________________
- ☐ Anxiety (0-10:) ____
- ☐ Panic Attacks ____
- ☐ Phobias ____
- ☐ Paranoia ____
- ☐ Bruxism ____
- ☐ Obsessive Rumination/Worry (0-10:) ______________________________
- ☐ OCD ____
- ☐ Eating disorders ____
- ☐ Risk-taking behavior ______________________________________
- ☐ Delusions, Hallucinations or Thought Disorder; ___Mental Fogginess (0-10:); ___Reactive Attachment Disorder; ___ODD; ___Arrests; ___Onset Insomnia (0-10:); ___Frequent Awakening (#/night:); ___Early Morning Awakening; ___Autism; ___Asperger's; ___Sexual Addiction; ___Compulsive Gambling; ___DID/DDNOS; Amount of Caffeine Use: ____Alcoholism; ____Substance Abuse:

Physical Traumas:

- ☐ Accidents ____
- ☐ Coma ____
- ☐ High fever ____
- ☐ Serious illness ____
- ☐ Surgery ____
- ☐ CNS infection ____
- ☐ Drug overdose/poisoning ____________________________

Psychological Trauma____

____
____

Psychological Stresses/Life Changes:

- ☐ Death in family ____
- ☐ Divorce/remarriage ____
- ☐ Move ____
- ☐ School change ____
- ☐ Job change ____
- ☐ Illness ____

SLEEP history

____

EXERCISE history

____

NUTRITION history

____
____
____

I feel better when I eat__________________________________drink_________________
____

Cravings:____

SUBSTANCE USE history

____

FAMILY HISTORY OF (Identify Who):

- ☐ Depression and/or Suicide: ____
- ☐ Bipolar/Manic Depression: ____
- ☐ Epilepsy: ____
- ☐ Migraine: ____
- ☐ Alcoholism or Drug Abuse: ____
- ☐ Anxiety or Panic Attacks: ____
- ☐ Tourette's (Motor or Vocal Tics): _____________________________________
- ☐ ADD/ADHD: ____
- ☐ Learning Disability: ____
- ☐ Speech Problems: ____
- ☐ Autism or Asperger's: ____
- ☐ Schizophrenia: ____
- ☐ OCD: ____
- ☐ PMS: ____
- ☐ Chronic Fatigue: ____

- ☐ Fibromyalgia: ____
- ☐ Criminal Behavior: ____
- ☐ Thyroid Problems: ____
- ☐ Dementia: ____

Notes (any other areas of health which have been bothering you): ___________________________
____

Describe your idea of wellness____
____
____
____

How will you know when you are done with therapy and training: _______________________
____
____
____