FitLife Wellness, LLC

Intake Form

Please provide the following information and answer questions below. Please note: information you provide here is protected as confidential information.

Please complete this form and bring it to your fist session.

Name:_____

(Last) (First) (Middle Initial)

Date of Birth:_____/_____/_____ Age:_____ Gender: Male/Female (circle one)

Marital Status (circle one) Never Married / Domestic Partnership / Married / Separated / Divorced / Widowed

Please life any children/age:_____

Addres:_____

_____

Home Phone: ( ) - May we leave a message on this phone? Yes / No (circle one)

Cell/Other Phone: ( ) - May we leave a message on this phone? Yes / No (circle one)

Email address: _____

Preferred Method of contact:_____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, counseling, etc)? Yes / No (circle one) If yes, please explain:

_____

_____

Are you currently taking any medication? Yes / No (circle one) If yes, please list medications:

_____

_____

General Health and Mental Health Information

1.How would you rate your current physical health? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:_____
_____

2. How would you rate your current sleeping habits? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are currently experiencing:
_____
_____

3. How many times per week do you generally exercise?_____

What types of exercise do you participate in?_____

4. Please lift any difficulties you experience with your appetite or eating patterns:
_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? Yes / No (circle one)

If yes, approximately how long?_____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? Yes / No (circle one)

If yes, when did you being experiencing this?_____

7. Are you currently experiencing any chronic pain? Yes / No (circle one)

If yes, please describe:_____

8. Do you drink alcohol more than once a week? Yes / No How often?_____

9. How often do you engage in recreational drug use: Never / Daily / Weekly / Monthly (circle one)

10. Are you currently in a romantic relationship? Yes / No (circle one) If yes, how long?_____

On a scale of 1-10, how would you rate your relationship?_____

11. What significant life changes or stressful events have you experienced recently:_____
_____
_____

Family Mental Health History

In this section below, identify if there is a family history or any of the following. If yes, please indicate the family member's relationship to you in the pace provided (father, mother, grandmother, ect.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes/No	_____
Anxiety	Yes/No	_____
Depression	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obesity	Yes/No	_____
Obsessive Compulsive Behavior	Yes/No	_____
Schizophrenia	Yes/No	_____
Bipolar Disorder	Yes/No	_____
Suicide Attempts	Yes/No	_____

Additional information:

1.Are you currently employed? Yes / No (circle one)

If yes, what is your current employment situation:_____

_____

Do you enjoy your work? Is there anything stressful about your current work?_____

_____

2.Do you consider yourself to be spiritual or religious? Yes / No (circle one)

If yes, describe your faith or belief:_____

_____

3. What do you want to accomplish out of your time in therapy?

_____

_____

_____