ERIKA BISCHOFF, LCSW

CBT Therapist

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form before your first session.

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Birth Date: ____/____/_____ Age: ____ Gender: ☐ Male ☐ Female ☐ Transgender

Ethnicity: _____ (optional) Primary Language: _____

Referred by (if any): _____

Name of parent/guardian, if applicable. Relationship to client: _____

_____
(Name) (Phone)

Marital Status:
☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children and age: _____

_____

Home Phone: (___) ___-____ May I leave a message? ☐ Yes ☐ No

Cell Phone: (___) ___-____ May I leave a message? ☐ Yes ☐ No
May I leave a text message? ☐ Yes ☐ No

Email: _____ May I email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: (___) ___-____

THERAPY GOALS

What do you consider to be some of your strengths?

What do you consider to be some of your challenges or needs?

What would you like to accomplish out of your time in therapy?

PRIOR TREATMENT

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ No ☐ Yes

If yes, previous therapist/practitioner: _____
(Name and phone number)

When and for how long? _____

What was the focus of treatment? _____

Are you currently taking any psychiatric medication? ☐ Yes ☐ No

If yes, please list: _____

Are you currently taking any other prescription medication? ☐ Yes ☐ No

If yes, please list: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current sleeping habits? (please check)
   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

2. How would you rate your current physical health? (please check)
   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in: _____

4. Describe any changes to your appetite in the last three months?
☐ Eating less ☐ Eating more ☐ Purging ☐ No change
Please list any difficulties you experience with your appetite/eating patterns, or past eating disorders:
_____

5. Are you currently experiencing any chronic pain? ☐ Yes ☐ No
If yes, please describe? _____

6. Have you ever experienced sadness, grief or depression for an extended period? ☐ Yes ☐ No
If yes, when and for approximately how long? _____

7. Have you ever experienced excessive anxiety, panic attacks or have any phobias? ☐ Yes ☐ No
If yes, when did you begin experiencing this? _____

8. Have you ever experienced mania (euphoria, rapid speech, risky impulsive acts)? ☐ Yes ☐ No
If yes, when did you begin experiencing this? _____

9. Have you ever experienced any hallucinations or delusions? ☐ Yes ☐ No
If yes, when did you begin experiencing this? _____

10. Have you ever struggled with alcohol or substance abuse? ☐ Yes ☐ No
If yes, for how long and are you in recovery? _____

11. Do you currently use alcohol? ☐ Yes ☐ No
If yes, how many times per week and how much? _____

12. Do you currently recreational drugs or non-prescribed prescription drugs? ☐ Yes ☐ No
If yes, what type, how many times per week and how much? _____

13. Are you experiencing any other addictive behaviors? ☐ Yes ☐ No
If yes, what kind and how is it a problem? _____

14. Are you currently in a relationship? ☐ Yes ☐ No
If yes, for how long? _____ On a scale of 1-10, how would you rate your relationship? ____

15. Are you currently experiencing any suicidal thoughts or have in the past? ☐ Yes ☐ No
If yes, please provide time frame and severity? _____

16. Are you currently experiencing any homicidal thoughts or have in the past? ☐ Yes ☐ No
If yes, please provide time frame and severity? _____

17. Are you currently experiencing incidents of self-harm or have in the past? ☐ Yes ☐ No
If yes, please provide time frame and severity? _____

18. Please identify any current and past trauma experiences (e.g., physical, emotional or sexual abuse; major accidents or natural disasters) and provide time period of trauma incident(s).

_____

_____

19. What significant life changes or stressful events have you experienced in the last year?

_____

_____

20. Are you currently working or in school? ☐ Yes ☐ No
If yes, what is your job/studies? Do you enjoy your job/school? Is there anything particularly stressful about your job/school?

_ _____

_____

21. Any other clinical issues or significant events that you would like me to know about?

_____

_____

FAMILY MENTAL HEALTH HISTORY
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	List Family Member(s), including yourself
ADHD	☐ Yes ☐ No
Alcohol/Substance Abuse	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Bipolar	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Domestic Violence	☐ Yes ☐ No
Eating Disorders	☐ Yes ☐ No
Obesity	☐ Yes ☐ No
Obsessive Compulsive Behavior	☐ Yes ☐ No
Schizophrenia	☐ Yes ☐ No
Suicide Attempts	☐ Yes ☐ No