Daniel Brewer, LPC

221 River Street 9th Floor
Hoboken, NJ 07030
daniel@danielsbrewer.com
(201) 721-8614

Intake Form

Name:_____ Date:_____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:
□ Medical Provider:
_____
□ Insurance Provider:
_____
□ My Website
□ Psychology Today website
□ Friend/Family: _____

Have you previously received any type of mental health services? □ No □ Yes

If yes, which of the following:

□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization

Name of provider or facility:

_____

Location: _____

Dates of treatment: _____

Reason for treatment:

_____

Briefly, what brings you in today?

When did your problem first start? Within the last:
□ 30 days □ 6-12 months □ 2 years □ During adolescence □ During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief, depression, or suicidal thoughts?
□ No
□ Yes: _____

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes: _____

If yes, when did you begin experiencing this? _____

Are you currently experiencing difficulty managing anger?

□ No
□ Yes:_____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

Family History

Where were you born?

_____

Where did you grow up?

_____

□ city □ suburbs □ country

Please list your parents, siblings or other significant family members. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they now live?	If deceased, age and cause of death

Who did you live with, growing up?

_____

Mother's occupation:

_____

Father's occupation:

_____

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.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	

Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : describe	

Please describe the nature of your relationships with family members, e.g., conflicted or supportive relationships:

Marital Status:
□ Never Married □ Domestic Partner □ Married
□ Separated □ Divorced □ Widowed

For how long?_____

Please give partners name: _____

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

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

Do you have any problems related to sexual functioning? If yes, please describe:

Do you have any problems related to sexual identity? If yes, please describe:

Please list any children of yours, their names, and ages:

Name	Age	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any specific health problems you are currently experiencing:

Please list any prescription medications, herbs, or supplements you have taken or are currently taking. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

Prescribing provider and contact information for current medications:

Name: _____

Specialty: _____

Facility: _____

Phone/Email/Fax number: _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep staying asleep awakening early sleep apnea nightmares

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise do you participate in?

Please list any difficulties you experience with your appetite or eating patterns:

_____

Any change in weight over the past year? □ No □ Yes:

How much? _____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe

_____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

Have you ever experienced any legal trouble? Yes No

If yes, please describe:

_____

Educational, Vocational, Interpersonal Functioning, and Additional Information

Please list your educational history including location and degrees earned:

Please list your work history and any significant challenges, adjustments, or disciplinary actions you have experienced?

What do you enjoy about your work? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

Please describe your social and emotional support system?

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

For Children:

Childs Developmental History:

Pregnancy/Delivery:

-Healthy Pregnancy?	Yes	No
-Full Term Delivery?	Yes	No
-Healthy at Birth?	Yes	No
-Low Birth Weight?	Yes	No

Briefly describe any concerns/difficulties regarding the conception, pregnancy, labor, or delivery of your child:

How would you describe your child as an infant/toddler?

Healthy – happy baby?	Yes	No
Easy to soothe?	Yes	No
Colicky?	Yes	No
Excessive Tantrums?	Yes	No
Did you have any toilet training concerns?	Yes	No
Were Developemental milestones met on time?	Yes	No

Please describe any delays in development, e.g., motor skills, speech:

Parental Relationship:

Parents' Current Status: Single Married Widowed Separated Divorced Remarried

Divorce/Custody/Visitation Concerns:

Is there parental/marital conflict?	Yes	No
Does the child directly witness arguing/fighting?	Yes	No
Is the child indirectly aware of arguing/fighting?	Yes	No

If yes, specify:

Academic History:

Current School: _____ Grade Level: _____

Most recent grades:_____ Are these grades typical for your child? Yes No

Has your child ever repeated a grade? Yes No If yes, which grade(s)? _____

Are you concerned about your child's academic achievement? Yes No

Are you concerned about your child's behavior at school? Yes No

Does your child have an Individual Education Plan (IEP) or 504 accomodations at school?