Kathryn J. Newton, L.C.S.W.
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(919) 929-5124

Confidential Intake Form

Name: _____

Address:_____

_____

Home Phone: _____ May I leave a message? Yes___ No ___
Cell Phone: _____ May I leave a message? Yes___ No____
Email _____May I email you? Yes __No ___

Emergency Contact - Name and Phone #_____

Birth Date: _____Age: _____Gender: _____

Please circle: Single Married Divorced Never married Widowed Separated

Names and ages of any children: _____

Occupation: _____
Employer:_____

Were you referred? _____By: _____

Have you previously received any mental health services? _____

If so, by whom? _____

HEALTH INFORMATION

Are you currently taking any prescription medications? _____

Please list: _____

Are you taking any vitamins or herbal supplements? _____

Please list: _____

How would you rate your current physical health (circle one):

Poor Fair Good Excellent

How would you rate your current habits (circle one):

Poor Fair Good Excellent

Do you exercise regularly? _____ If so, how often? _____

How would you rate your current diet (circle one):

Poor Fair Good Excellent

Any difficulties related to eating? _____ If so, please describe:_____

Any difficulties with sleep?_____

Do you experience chronic or regular pain?_____

Do you drink alcohol? _____How much? _____

Do you use recreational drugs?_____ What kind and how often? _____

Please list any medications you are currently taking_____
_____

Do you have any current health issues? _____

If so, please describe: _____
_____

Are you experiencing any of the following? (please circle)

Depression	PTSD	Suicidal Thoughts
Anxiety	Violence or Aggression	
Panic Attacks	Parenting Issues	
Phobias	Sexual Issues	
Eating Disorders	Infertility	
Excessive Stress	Addiction	

Anything not listed that is a concern:_____
_____

Please circle any of the following that applies to a family member and write next to it who: Bipolar Disorder_____ Depression_____
Anxiety_____Panic Disorder_____Schizophrenia_____
Eating Disorders_____Chronic Pain_____Suicidal_____
Domestic Violence_____Obesity_____Obsessive Compulsive_____
Alcohol Abuse/Dependence_____Hoarding_____

Are you in a romantic/intimate relationship?
For how long? _____

Please rate your current experience in this relationship (circle one):

Very Satisfied Satisfied Somewhat Dissatisfied Dissatisfied

Have you had any significant stresses or life changes recently? _____
If so, please describe:

_____
_____
_____

Please briefly describe what brings you to therapy.

_____
_____
_____

Please provide insurance company name and subscriber number.

_____
_____