Rachel McDavid & Associates, MFT, PC
Individual and Relational Counseling
Anger Management

INTAKE FORM

Name: _____Birth Date: _____ /_____ /_____ Age: _____

Address: _____City_____State____Zip_____

Home Phone: _____ Cell/Other Phone:_____

E-mail: _____ May we email you? □ Yes □ No

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

□ Single □ In Relationship □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Emergency Contact _____Phone_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

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? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

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

4. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No

□ Yes

If yes, for approximately how long? _____

5. Do you drink? _____ How much? _____

6. Do you take drugs?_____ If yes, what kind?_____ How often?_____

7. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

8. Have you ever been hospitalized for psychiatric reasons? _____

9. Are you currently taking any prescription medication?

□ Yes

□ No

If yes, please list: _____

What do you hope to gain by coming here?_____

_____

How did you find us?:

_____`