The Way Center
2352 Meadows Blvd. Suite 170
Castle Rock, CO 80109
720-457-2400

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

THERAPY INTAKE FORM

Date of Birth:	Current Date:
Last Name:	First Name:
Home Address:	City, State and Zip:
Cell Phone:	Email:
Current School:	Grade:
Extracurricular activities:	

MENTAL HEALTH HISTORY / STATUS

In your own words, describe the issues for which you are seeking help:

How long have you been dealing with them and what made you seek out therapy now?

What do you hope to accomplish during your time in therapy?

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Please check all that apply:

☐ Depressed mood	☐ Weight loss / gain	☐ Difficulty falling asleep
☐ Difficulty staying asleep	☐ Difficulty getting out of bed	☐ Not feeling rested in the morning
☐ Loss of interest in activities	☐ Withdrawal / isolation	☐ Feeling numb
☐ Feeling guilty / worthless	☐ Feeling hopeless / helpless	☐ Thoughts of death / suicide
☐ Irritability	☐ Self-harm	☐ Rapid mood changes
☐ Anxiety	☐ Panic attacks	☐ Racing thoughts
☐ Difficulty leaving your home	☐ Difficulty concentrating	☐ Angry outbursts
☐ Fear of specific objects / situations	☐ Repetitive thoughts / behaviors	☐ Avoiding people / places
☐ Excessive worry	☐ Intrusive memories	☐ Impulsive behavior
☐ Easily startled / jumpy	☐ Tense / unable to relax	☐ Flashbacks
☐ Violent thoughts / behaviors	☐ Nightmares	☐ Agitated / restless
☐ Increased energy	☐ High risk behaviors	☐ See / hear things that are not real
☐ Suspect things may not be real	☐ Feel outside of self	☐ Recent loss / grief
☐ Work / school problems	☐ Relationship problems	☐ Concerns about sexuality
☐ Difficulty expressing emotion	☐ Difficulty communicating	

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Have you received counseling or psychotherapy in the past? ☒ Yes ☐ No

If yes, name of therapist or practitioner:

Have you been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes:

Hospital:

Dates:

Have you ever had outpatient treatment by a psychiatrist? ☐ Yes ☐ No

If yes:

Practitioner:

Date:

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list medication and date prescribed:

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, please explain content:

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MEDICAL HISTORY

Please list any medical conditions for which you are currently receiving treatment:
Please list any serious medical illnesses and procedures you have had in the past:
Are you currently taking any prescription medication? ☐ Yes ☐ No If yes, please provide list and dates:

Alcohol, Drug and Tobacco Use:

Describe your use of alcohol:

Describe your use of recreational drugs:

Describe your use of tobacco/vaping:

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FAMILY MEDICAL HISTORY

Please list any history of illness (mental or other) and substance use among your relatives:

Mother's Side:

Father's Side:

SOCIAL HISTORY

Where were you born? Where did you grow up?

Are your parents divorced? ☐ Yes ☐ No

If yes, how old were you when they separated?

Father's Occupation: Mother's Occupation:

How many siblings do you have? What are your siblings' ages?

Are you close with your siblings?

Did you have any early developmental problems as a child? ☐ Yes ☐ No
If yes, please explain:

Have you ever been or are you currently being abused? ☐ Yes ☐ No
☐ Physically
☐ Sexually
☐ Emotionally

Do you or have you had any disciplinary problems in school? ☐ Yes ☐ No
If yes, please explain:

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SOCIAL HISTORY (Continued)

Please list any jobs you have had:

Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, duration:
If yes, please describe your relationship:

Have you ever been pregnant? ☐ Yes ☐ No

Who currently lives in your residence (name, age, relationship to you)?

Have you ever been arrested? ☐ Yes ☐ No
If yes, please describe:

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

What activities do you enjoy?

Please add additional information you think would be helpful for treatment:
