Cornerstone Mental Healthcare, PLLC/ Cornerstone Mental Healthcare Ohio, LLC

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INTAKE FORM

Legal Name:

Date:

Some of these questions are very personal in nature-only share what you are comfortable disclosing.

Any information you share will help me in our work together and it will make our first session together more productive.

1. PREFERRED NAME:
2. DATE:
3. GENDER:
4. SEXUAL IDENTITY:
5. DATE OF BIRTH and PLACE OF BIRTH:
6. AGE:
7. ADDRESS:
8. HOME PHONE:
9. CELL:
10. EMAIL:
11. NUMBER WHERE I CAN LEAVE A CONFIDENTIAL VOICEMAIL AND/OR TEXT MESSAGE (texting is not HIPAA Compliant):
12. EMERGENCY CONTACT:
13. TELEPHONE:
14. HOW DID YOU HEAR ABOUT CORNERSTONE MENTAL HEALTHCARE?

15. OCCUPATION (former, if retired):

16. WHY ARE YOU SEEKING HELP?

17. Have you ever had an experience that you consider traumatic? When did this happen and does the experience still bother you now? What was the traumatic event?

18. Marital/relationship status:

19. Partner Name:

20. Years together:

21. Do you live together?

22. PRESENT SPOUSE/PARTNER. Please describe what your relationship is like:

23. Please list everyone who lives in your house with you, including pets (what is their relationship to you?):

24. Please describe your relationships with your family members.

25. COMMUNITY, & SPIRITUALITY: FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

26. DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

27. HEALTHCARE PROVIDERS. Please list name and phone number of medical doctors, therapists or other providers whose care you are currently under:

28. LIST ANY CURRENT OR PAST MENTAL HEALTH MEDICATIONS (prescriptions, supplements or over the counter medications, the dosage, and why you are/were taking it:

29. Have you ever attempted suicide? If so, please describe the circumstances, including ages, reasons, how, etc.:

30. Current medical conditions/injuries/disabilities/allergies and medications:

31. EXERCISE. Please describe your activity level, forms of exercise and number of times per week:

32. DIET: Please describe your diet and whether you consider it to be healthy for you:

33. Have you ever been treated for drug/alcohol abuse or addiction (AA, NA, treatments)? If so, please list:

34. ALCOHOL: Number of drinks per day: Per week:

35. Caffeine: Amount per day and type:

36. Marijuana: Amount, frequency, method of use:

37. Nicotine: Amount, frequency, method of use:

38. Other recreational substances:

39. Please add any other information you would like me to know about you and your situation: