**Kristy Hellum, MFT**

**707 599-2000 608 College Ave Santa Rosa**

I N T A K E F O R M

*Please provide the following information to help me be of service to you. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle one: Cell or Home?

email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status:

□ Married □ Single □ Committed relationship not married □ it's complicated

If in relationship, how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your current relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? □no □yes

name and ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

□No □Yes with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous psychotherapy? □No □Yes

Previous therapist’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □Yes □No

If Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, have you been previously prescribed psychiatric medication? □Yes □No

If Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH AND SOCIAL INFORMATION**

How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other \_\_\_\_\_\_

4. How many times per week do you exercise? \_\_\_\_\_\_\_\_\_\_

Approximately how long each time? \_\_\_\_\_\_\_\_\_\_

1. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable:

□ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months?

□No □Yes

1. Do you regularly use alcohol or other drugs? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?\_\_\_\_\_

7. Do you smoke cannabis? □ Daily □Weekly □Monthly □Rarely □Never

What other drugs have you used in the last 6 months?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?

* Frequently □ Sometimes □ Rarely □ Never

9. In the last year, have you experienced any significant life changes or stressors? Please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced:

Extreme depressed mood yes/no Wild Mood Swings yes/no

Rapid Speech yes/no Extreme Anxiety yes/no

Panic Attacks yes/no Phobias yes/no

Sleep Disturbances yes/no Hallucinations yes/no

Unexplained losses of time yes/no Unexplained memory lapses yes/no

Alcohol/Substance Abuse yes/no Frequent Body Complaints yes/no

Eating Disorder yes/no Body Image Problems yes/no

Homicidal Thoughts yes/no Suicide Attempt yes/no

Repetitive Thoughts (e.g., Obsessions) yes/no

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy at your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any work-related stressors, if any :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be spiritual person? □ No □ Yes

Please circle any of these practices that you have ever found helpful:

Journaling Meditating Being in Nature

Yoga Qi Gong Tai Chi

Walking Meditation Affirmations Reading Scripture

Reading or writing Poetry Running Ecstatic Dance

Tarot Singing Chanting

Art making Praying other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consider yourself to belong to a religious faith? □ No □ Yes

If yes, what is your faith? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

(circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Depression yes/no

Bipolar Disorder yes/no

Anxiety Disorders yes/no

Panic Attacks yes/no

Schizophrenia yes/no

Alcohol/Substance Abuse yes/no

Eating Disorders yes/no

Learning Disabilities yes/no

Trauma History yes/no

OTHER INFORMATION:

What do you consider to be your strengths?

What are your goals for therapy?

**Or circle those that may apply:**

Improve communication with loved ones decrease worry and anxiety,

addiction recovery find a healthy relationship

feel more joy love my self more

understand repeated patterns in my life become independent

make a major life decision save my marriage

forgiveness Freedom for self-expression

examine sexuality and healthy choices find a better job/career

heal childhood wounds feel more energetic and happy

**Thank you**