Filaski Psychological Care, P.C.

Intake Forms

Name:_____ Date:_____
Age:_____

Have you been to therapy before? _____

Are you currently taking any prescription medication?_____

Have you taken prescription medication in the past?_____

List any ongoing medical issues/concerns you experience with your physical health:

_____

What are you seeking help for therapeutically and what are your treatment goals?

_____

_____

Symptom Checklist for symptom you are experiencing currently (check all that apply):

- Anxiety
- Panic attacks
- Sadness/Depression
- Grief
- Thoughts of hurting self
- Difficulty sleeping
- Perseverative thoughts
- Phobias
- Chronic pain
- Obsessive compulsive behaviors
- Eating disorders or issues with eating
- Addiction (drugs/alcohol/prescription meds)
- Hallucinations or Delusions
- Tics

Do you drink alcohol?_____Engage in recreational drug use?_____

List any significant life changes recently:_____

Who do you live with?_____

Are you currently in a relationship?_____

Trauma History (check all that apply):

- Verbal/Emotional Abuse
- Physical Abuse
- Sexual Abuse
- Rape/Sexual Assault
- Accident or Traumatic Event
- Domestic Violence

Family History of Anxiety, Depression, Bipolar Disorder, ADHD, Alcoholism/Addiction, Schizophrenia or other psychological disorders?

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