Cheri Tarutani, LLC

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Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session.

PERSONAL INFORMATION

Name:

____

(Last) (First) (Middle Initial)

Birth Date: _______ /_______ /_______ Age: _________ Gender: ☐ Male ☐ Female ☐

Ethnicity: ______________________

Address:

____

(Street and Number)

____

(City) (State) (Zip)

Home Phone: ( ) ______________________ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: ( ) ______________________ May we leave a message? ☐ Yes ☐ No

E-mail: ____

May we email you? ☐ Yes ☐ No **Please be aware that email might not be confidential.*

Referred by:

____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐ Yes ☐ No If yes, therapist/practitioner: ____________________________________

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

☐ No ☐ Yes, previous therapist/practitioner:

____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
☐ Yes ☐ No If Yes, please list prescription and condition treating:

____

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

If Yes, please list prescription and condition treating:

____

HEALTH AND MENTAL HEALTH INFORMATION
When was your last physical exam and by whom was it conducted? ____________________

1. How is your physical health at present? (please circle) Poor Unsatisfactory Satisfactory Good Very good

2. Please list any health problems that you have (for example, allergies, migraines, diabetes, arthritis, high blood pressure, etc.):

____

____

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

____

Are you currently taking any prescription medication? ☐ Yes ☐ No
Please list prescription and condition treating:

____

____

Have you ever had any allergic reactions to any medicinal agents? ☐ Yes ☐ No
If yes, please explain:

____

4. How many times per week do you exercise? ____________ Approximately how long each time? ____________

5. Are you having any difficulty with appetite or eating habits? ☐ No ☐ Yes If yes, check where applicable:
____ Decreased appetite
____ Increased appetite
____ Frequent nausea or gastrointestinal distress
____ Weight change in last month: __________________
____ Other troublesome symptoms. Please specify:

____

____

6. Do you regularly use alcohol? ☐ No ☐ Yes If yes, how many drinks per week? __________________

Do you use caffeine? Yes No How many drinks per day? ____________________
Do you smoke cigarettes? Yes No How many packs per day? ____________________
Do you use other tobacco products? Yes No How often?_____________________

7. Are you having any problems with your sleep habits? ☐ No ☐ Yes If yes, check where applicable:
____ Can.t get to sleep
____ Can.t stay asleep
____Persistent daytime fatigue
____ Waking up early in the morning and can.t get back to sleep
____ Sleeping too much

____ Sleeping too little
____ Poor quality sleep
____ Disturbing dreams
____ Other ______________________________

8. In the last year, what significant life changes or stressful events have you experienced:
____
____

9. Are you currently experiencing
____ Overwhelming sadness, grief, or depression
____ Fatigue or low energy
____ Depressed mood, feeling down or blue most of the time
____ Not enjoying things you usually enjoy
____ Feeling slowed down or very sluggish
____ Feeling nervous, agitated, or antsy
____ Feeling worthless or guilty
____ Can.t concentrate or pay attention
____ Can.t make decisions
____ Poor self-esteem
____ Irritable, cranky, out-of-sorts
____ Crying spells
____ Not interested in sex or other sexual issues
____ Drinking more alcohol than usual
____ Feeling anxious most of the day
____ Frequent thoughts of death or dying
____ Excessive worrying
____ Feeling like life is not worth living
____ Panic episodes (e.g., palpitations, sweating, shaking, shortness of breath, nausea or dizziness, feeling that the world is coming to an end)
____ Don.t want to leave the house or go out in public
____ Increase in aches and pains (headaches, stomach distress, etc.)
____ Repetitive thoughts that you can.t get out of your mind

SOCIAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes If yes, what is your current employment situation?
____
Highest level of education: High School diploma GED Some College Bachelors Masters Doctorate
Do you enjoy your work? Is there anything stressful about your current work?
____
____

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

2. Are you currently in a romantic relationship? ☐ No ☐ Yes If yes, how long have you been in this relationship? ____________________ On a scale of 1-10, how would you rate the quality of your current relationship? ________

Spouse/partner’s first name and occupation:

____

First names and ages of children:

____

____

3. Do you consider yourself to be religious? ☐ No ☐ Yes If yes, what is your faith?

____

If no, do you consider yourself to be spiritual? ☐ No ☐ Yes

4. Do you identify with a particular culture or cultures? ☐ No ☐ Yes If yes, which one(s)?

____

FAMILY MENTAL HEALTH HISTORY:
Mother.s occupation: ____
Mother.s current age or date of death: _________________________________
Father.s occupation: ____
Father.s current age or date of death: _________________________________
Siblings: Number of sisters _______ Number of brothers _______ Number of step/adoptive/foster siblings ________
Who reared you if you were not reared by your biological or adoptive parents?

____

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.):

Difficulty	Family Member(s)
____ Depression	______________________
____ Anxiety	______________________
____ Panic Attacks	______________________
____ Bipolar disorder	______________________
____ Personality disorder	______________________
____ Alcoholism	______________________
____ Other drug use	______________________
____ Schizophrenia	______________________
____ Attempted suicide (tried but lived)	______________________
____ Completed suicide (died as result)	______________________
____ Other psychiatric disorder	______________________

OTHER INFORMATION:
What do you consider to be your strengths?

____

____

What do you like most about yourself?

____

____

What are effective coping strategies that you’ve learned?

____

____

What are your goals for therapy?

____

EMERGENCY CONTACT: In the event of an emergency, whom should we contact?
Name: ____
Address: ____
Relationship to you: ____
Phone numbers: Home ________________________ Business ________________________
Cell: ___________________________________