



2209 E Market St  
 York, PA 17402  
 Phone: (717)759-1024

### Intake Form (14 years old and Adult)

Please complete this form to the best of your knowledge. Please know that all content shared on this intake form will be held confidential and not shared without your consent. If there is anything that you wish to not share, leave those questions blank. If there are any questions that do not pertain to you, please mark that as N/A and move to the next.

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone number \_\_\_\_\_

Can a message be left on the voicemail? ( ) yes ( ) no

Address \_\_\_\_\_

Preferred Pronouns \_\_\_\_\_ Gender \_\_\_\_\_

Is there a religion consideration that you would like the therapist to know yes ( ) no ( )

If yes, please explain \_\_\_\_\_

Emergency Contact (name & number) \_\_\_\_\_

How did you find Therapeutic Family Connections? \_\_\_\_\_

Please list all healthcare providers. Can they be contacted to collaborate care ( ) Yes ( ) No

Name

Phone Number

Agency

	Name	Phone Number	Agency
Case Worker			
Nutritionist			
Primary Care Physician			
Psychiatrist			
Other			



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Are there any special needs that should be noted? Hearing aid devices, interpreter, mobility assistance, ect.?

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**Presenting Difficulty**

Have you been to therapy before and what was your experience like? (With whom, when and outcome)

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What are the areas of concern? Why are you seeking therapy? \_\_\_\_\_

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What would your treatment plan goals be? What would you hope to accomplish? In what areas would you like to improve, learn, and develop? \_\_\_\_\_

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Please check off any symptoms that apply and the severity within the last two weeks. Any symptoms that may have been missed can be explained in the spaces below.

Symptoms you have experienced within the last <b>two weeks</b>	<b>Mild</b> Several days	<b>Moderate</b> More than half the days	<b>Severe</b> Nearly every day	Symptoms you have experienced within the last <b>two weeks</b>	<b>Mild</b> several days	<b>Moderate</b> More than half the days	<b>Severe</b> Nearly every day
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Aggression toward others				Indecisiveness			
Aggression toward animals				Infidelity			
Anger				Isolated			
Anxiety				Legal Issues			
Avoidant Behaviors				Lonely			
Bing Eating				Lying			
Compulsive Behaviors				Manipulative			
Crying				Memory Loss			
Controlling Behaviors				Mood Swings			
Decreased Concentration				Nightmares			
Decreased Pleasure in Doing Things				Night terrors			
Decreased Trust in others				Obsessive Thoughts			
Depression				Oppositional Defiance			
Drug / Alcohol Use				Overeating			
Enuresis / Encopresis				Panic Attacks			
Fear				Physical Fighting			
Feeling like a Burden				Physical Pain			
Feeling Worthless				Poor Self-Esteem			
Financial Problems				Pornography			
Fire Setting				Post-Partum Depression			
Flashbacks				Purging Food			
Gambling				Racing Heart			
Grandiose Thoughts of self				Relationship Difficulties			
Hallucinations				Restricting Food			
Headaches				Risk Taking			



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Hearing Voices				Self-Harm Behaviors			
Hoarding				Sexual Dysfunction			
Homicidal Ideation				Sexual Identity Confusion			
Difficult Impulse Control				Sexual Promiscuity			
Increase in Stress							
Increased Irritability							

Please explain any of your answers \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please circle the number that indicates how motivated you are for change.

1      2      3      4      5      6      7      8      9      10

Minimally Motivated                      Moderately Motivated                      Highly Motivated

Please list all prescribed, over the counter, and homeopathic medications that you are currently taking.

Medication name	Dose	Dosage Instructions	Prescribed By	What is the medication prescribed for?

Please check any past psychiatric medications that have been taken, date they were taken, and how helpful they were. Please list what you remember. \_\_\_\_\_



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Please indicate any current or past treatment that you have been involved in.

Yes	No	Treatment	When	Were	Outcome
		Drug/Alcohol Treatment			
		Outpatient Therapy			
		Partial Hospitalization			
		Psychiatric Hospitalization			
		Support Groups			

Additional space for other treatments that are not listed \_\_\_\_\_

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Any **past** or **current** thoughts/plans/acts/ideation or intention of suicide? Please explain or write N/A if it does not apply. \_\_\_\_\_

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Any **past** or **current** thoughts/plans/acts/ideation or intention of homicide? Please explain or write N/A if it does not apply. \_\_\_\_\_

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Any **past** or **current** thoughts/plans/acts/ideation or intention of self-harm? Please explain or write N/A if it does not apply. \_\_\_\_\_

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Has anyone in your social circle or family ever died by suicide? If yes, please explain. \_\_\_\_\_

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### Family History

Has anyone in your family ever been diagnosed and treated for. If so, who?

Alcohol abuse \_\_\_\_\_

Anxiety \_\_\_\_\_

Bipolar disorder \_\_\_\_\_

Depression \_\_\_\_\_

Intellectual disabilities \_\_\_\_\_

Eating Disorders \_\_\_\_\_

Panic Attacks \_\_\_\_\_

Personality Disorder \_\_\_\_\_

Post-Traumatic Stress Disorder \_\_\_\_\_

Substance abuse \_\_\_\_\_

Has anyone in your family ever taken psychiatric medications. If yes, who took what medications and how effective treatment was? \_\_\_\_\_



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What family members are involved in your life?

Relationship	Name	Age	Description (supportive, angry, controlling, kind, ect)
Mother			
Step-father			
Father			
Step-father			
Siblings			
Spouse / Partner			
Children			

Please provide the names of any additional support that are involved in your life. \_\_\_\_\_

**Relationship History**

Are you currently Married ( ) Divorced ( ) Single ( ) Widowed ( ) In a relationship ( )

Have you been married before? \_\_\_\_\_

Are you sexually active? \_\_\_\_\_

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

How would you describe your current relationship? \_\_\_\_\_



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Do you have any children yes ( ) no ( )

If yes, list name, ages, and gender \_\_\_\_\_

\_\_\_\_\_

Describe your relationship with your children. \_\_\_\_\_

\_\_\_\_\_

Who do you live with? \_\_\_\_\_

\_\_\_\_\_

**Substance Use**

Please check all that applies to current and past substance use. If non-applicable, move to the next section.

Substance Type	Yes	No	Current Use (Within 6 months)	Amount / Frequency	Yes	No	Past Use	Amount/ Frequency
Alcohol								
Caffeine								
Crack/ Cocaine								
Ecstasy								
Heroin								
Inhalants								
Marijuana								
Methamphetamines								
Nicotine Vape								
Painkillers- Not prescribed								
PCP/LSD								



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<b>Prescription Pills</b>								
<b>Sleeping Pills</b>								
<b>Stimulants</b>								
<b>Steroids</b>								
<b>Tobacco</b>								

Are you currently in need of treatment for your substance use? ( ) yes ( ) no

When was the last time there was substance use and what substance was it? \_\_\_\_\_

Has your use of substances interfered with your daily life? \_\_\_\_\_

Has your substance use ever interfered with any relationships? \_\_\_\_\_

Has your substance use caused any legal problems? \_\_\_\_\_

Have you found yourself using more substances over time? \_\_\_\_\_

Is there any history of gambling? If yes, please explain \_\_\_\_\_

Is there any history of sexual acting out, pornography, sex crimes, legal charges, harmful behaviors, etc.?  
 \_\_\_\_\_

Is there any history of overeating, bingeing, restricting, and / or purging food?  
 \_\_\_\_\_

### Medical History

Please check all medical history that applies to you or anyone in your family. Please mark you, or which family member the condition applies to.

- |                           |                             |                        |
|---------------------------|-----------------------------|------------------------|
| Allergies _____           | Asthma _____                | Cancer (type) _____    |
| Chronic Fatigue _____     | Chronic Pain _____          | Diabetes _____         |
| Epilepsy / Seizures _____ | Fibromyalgia _____          | Head trauma _____      |
| Heart Disease _____       | High Blood Pressure _____   | High Cholesterol _____ |
| Infectious Disease _____  | Stomach / GI Problems _____ | Thyroid Disease _____  |
| Other _____               |                             |                        |



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Past medical difficulties, including surgeries and hospitalizations? Please explain or write N/A \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any allergies or special precautions that should be known about? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Women Only**

Date of your last menstrual cycle? \_\_\_\_\_

Are your menstrual cycles consistent each month? \_\_\_\_\_

Are you currently pregnant, or do you think you may be pregnant? \_\_\_\_\_

Are you planning to get pregnant in the near future? \_\_\_\_\_

Birth control method? \_\_\_\_\_

Do you have any concerns about your physical or reproductive health that you would like to discuss in therapy?  
\_\_\_\_\_

Were there any complications when your mother was pregnant with you or during birth?  
\_\_\_\_\_

**Trauma History**

Have you ever experienced any of the following? Circle all that apply

- |                 |                 |                   |
|-----------------|-----------------|-------------------|
| Emotional Abuse | Sexual Abuse    | Domestic Violence |
| Physical Abuse  | Neglect         | Caregiver Abuse   |
| Verbal Abuse    | Witnessed Abuse |                   |

Please explain any of the above \_\_\_\_\_  
\_\_\_\_\_



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Have you ever received treatment for any of the experienced trauma? If so, where, from whom, and when?

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What was the outcome of the treatment? \_\_\_\_\_

Are you currently safe? ( ) yes ( ) no

**Educational / Occupation History**

Highest grade completed? \_\_\_\_\_

Where did you complete your highest grade level? \_\_\_\_\_

Are there any academic difficulties? \_\_\_\_\_

Is there a history of developmental delays? ( ) yes ( ) no

If yes, please explain \_\_\_\_\_

What are your strengths in your academics? \_\_\_\_\_

What is your learning style? (Auditory- by hearing information, Kinesthetic- by doing, Read / Write, or Visual)

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Did you attend College? \_\_\_\_\_

If yes, where? \_\_\_\_\_

What was your major? \_\_\_\_\_

Are you currently ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

If you are working, what is your occupation? \_\_\_\_\_

How long have you been at your current employer? \_\_\_\_\_

What is your work schedule? \_\_\_\_\_

Have you ever been in the military? \_\_\_\_\_



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If yes, which branch and when? \_\_\_\_\_

Are you still active duty? \_\_\_\_\_

Were you discharged honorably? Yes ( )\_ no ( )

If not honorably discharge, please explain \_\_\_\_\_

### Legal History

Have you ever been arrested? If yes, please explain (when and for what) \_\_\_\_\_

Have you ever been to jail / prison? When and for what \_\_\_\_\_

Do you have any pending legal problems? If yes, please explain. \_\_\_\_\_

Have you ever been on parole or probation? If yes, please explain. \_\_\_\_\_

Any additional information that would be helpful for your therapist to know?

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

**By signing below, you are attesting that the above information is completed to the best of your ability.**

**Your signature is also consenting to the agreement of the above information.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature (If under 18) \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_



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