Dr. Laura A. Zipris, PA

561-558-7815

INTAKE FORM

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential information.

NAME:____
(Last) (First) (Middle Initial)

NAME of Parent of Guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Birth Date:______/_______/______ **Age:** ________ **Gender:** ☐ Male ☐ Female

Marital Status: ☐Never Married ☐ Domestic Partnership ☐Married
☐Separated ☐Divorced ☐Widowed

Please list any children/age:-____

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

Email: ___________________________________ **May we email you?** ☐ Yes ☐ No

Referred by (if any):____

May I thank them: ☐ Yes ☐ No

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, evaluations, etc.)? ☐ No ☐ Yes, previous therapist practitioner

____

____

Are you currently taking any prescription medication? ☐ No ☐ Yes, please list: ____________

____

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes, please list, provide dates, and indicate who prescribed(s) the drugs to you:

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are experiencing:

____

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are experiencing:

____

____

3. How many times per week do you generally exercise?_____________

What types of exercise do you participate in:

____

____

4. Please list any difficulties you have with your appetite or eating patterns

____

____

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5. Are you currently experiencing overwhelming sadness grief or depression? ☐ No ☐ Yes

If yes, for how long____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes

If yes, please describe:

____

____

7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe:

____

____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage in recreational drugs: ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes
If yes, for how long?____
On a scale of 1-10, how would you rate your relationship?_____________

11. What significant life changes or stressful events have you experienced recently?:

____

____

____

FAMILY MENTAL HEALTH HISTORY: In this section, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (i.e., father, grandmother, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	

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Depression	yes / no
Domestic Violence	yes / no
Eating Disorders	yes / no
Obesity	yes / no
Obsessive Compulsive Disorders	yes / no
Schizophrenia	yes / no
Suicide Attempts	yes / no

____
____

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes

If yes, what is your employment situation:

____
____

Do you enjoy work? Is there anything stressful about your current work?:

____
____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief: ____
____
____

3. What do you consider some of your strengths?

____
____
____

4. What do you consider to be some of your weaknesses?

____
____
____

5. What would you like to accomplish our of your time in therapy?

____
____
____
____

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