Coastal Synergy
ASSOCIATES

INTAKE FORM

Please fill out this biographical background form as completely as possible. It will help me in our work together. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: ________________________________ **DOB:** __________________ **AGE:** ________

ADDRESS:____
____

TELEPHONES: H: ________________ Cell: _________________ Work/Off: ______________

FOR ROUTINE MESSAGES: Phone #_________________ Email: ______________________

PERSON & PHONE NO. TO CALL IN EMERGENCY:
____

REFERRAL SOURCE:____

Marital status: ________________________ Live with someone? ______________

If so, Name:_______________________________________Occupation:____________________

Name: ____Years: _________________

PAST & PRESENT MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):
____
____
____
____
____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

1.____

2.____

3.____

4.____

5.____

Reason(s) for seeking services:

What goals do you have for services?

CHECK ANY ISSUES YOU HAVE EXPERIENCED CURRENTLY OR IN THE PAST

	Mild	Moderate	Severe		Mild	Moderate	Severe
Sleep issue - falling asleep	☐	☐	☐	Hopelessness	☐	☐	☐
Sleep issue - staying asleep	☐	☐	☐	Helplessness	☐	☐	☐
Anger	☐	☐	☐	Impulsivity	☐	☐	☐
Anxious	☐	☐	☐	Irritability	☐	☐	☐
Bingeing/Purging	☐	☐	☐	Isolation	☐	☐	☐
Concentration problems	☐	☐	☐	Hyperactivity	☐	☐	☐
Delusions	☐	☐	☐	Mania	☐	☐	☐
Depressed mood	☐	☐	☐	Memory problems	☐	☐	☐
Decreased energy	☐	☐	☐	Mood lability	☐	☐	☐
Flashbacks	☐	☐	☐	Nightmares	☐	☐	☐
Grief	☐	☐	☐	Obsessions/compulsion	☐	☐	☐
Guilt	☐	☐	☐	Panic attacks	☐	☐	☐
Hallucinations	☐	☐	☐	Restricted eating	☐	☐	☐

Homicidal	☐	☐	☐	Sexual problems	☐	☐	☐
Suicidal thoughts	☐	☐	☐				
Tearfulness	☐	☐	☐				
Worthlessness/Low self-esteem	☐	☐	☐				
Weight Gain	☐	☐	☐				
Weight Loss	☐	☐	☐				
Other	☐	☐	☐				

PSYCHOSOCIAL HX

Where were you born? ______________________

Occupation:______________________

Financial Stressors

☐ Yes

☐ No

FAMILY Hx

Relationship with Mother

☐ Yes

☐ No

☐ Adopted

☐ Biological

Describe______________________

____

Relationship with Father

☐ Yes

☐ No

☐ Adopted

☐ Biological

Describe______________________

____

Relationship with Siblings

○ Yes

○ No

Describe______________________

____

Highest Grade Level: ______________________

Satisfied with job?:______________________

Relationship with Stepparent(s)

○ Yes

◉ No

Describe______________________

____

PSYCHOSOCIAL STRESSORS

Lost important relationships

○ Yes

○ No

Describe______________________

____

Accident w/ Injury Hx

○ Yes

○ No

Describe______________________

____

Health

☐ Good

☐ Fair

☐ Poor

Describe______________________

____

Death in Family
- ◯ Yes
- ◯ No

Who/When/ How ______________________________

____

Legal Problems
- ◯ Yes
- ◯ No

Describe______________________________

____

Self Injury Hx
- ◯ Yes
- ◯ No

Describe______________________________

____

SUBSTANCE ABUSE/USE HX
- ☐ None
- ☐ Nicotine
- ☐ Caffeine
- ☐ Alcohol
- ☐ Cocaine
- ☐ Benzodiazepines
- ☐ Cannabis
- ☐ Opiates
- ☐ Barbiturates
- ☐ Ecstasy
- ☐ LSD
- ☐ Other

Past Substance Treatment
- ◯ Yes
- ◯ No

Describe______________________________

____

Past Mental Health Treatment
- ◯ Yes
- ◯ No

Describe______________________________

____

Family Hx of Mental Illness or Substance Use/Abuse
- ◯ Yes
- ◯ No

Describe______________________________

____

Abuse Hx - Victim
- ☐ None
- ☐ Emotional
- ☐ Physical
- ☐ Sexual
- ☐ Other

Describe______________________________

____

Abuse reported
- ◯ Yes
- ◯ No

Describe______________________________

____

Abuse History - Perpetrator
- ☐ Denied
- ☐ Emotional
- ☐ Physical
- ☐ Sexual
- ☐ Other

Describe______________________________

____

Abuse reported
- ◯ Yes
- ◯ No

Describe______________________________

____

Suicidal Thoughts

- ☐ None
- ☐ Thoughts
- ☐ Plan
- ☐ Intent

Describe____

____

Homicidal Thoughts

- ☐ None
- ☐ Thoughts
- ☐ Plan
- ☐ Intent

Describe____

____

Current Medications

- ○ Yes
- ○ No

List:____

____

____

____

____