Shelafoe Therapy Intake Form

Mike Shelafoe, LMSW

Demographic Information

Full Name: ____ Date: _____ / _____ / _____

Birth Date: _____ /_____ /_____ Age: ______ Parent/guardian (if under 18): ____________________

Gender: ______ Marital Status: _____ Never Married _____ Domestic Partnership _____ Married

_____ Separated _____ Divorced _____ Widowed

Children/ages: ____

Address: ____

Phone #: _________________________________ May I leave a message? _____ Yes _____ No

Cell #: __________________________________ May I leave a message? _____ Yes _____ No

E-mail: ____ May I email you? _____ Yes _____ No

Are you employed? _____ Yes _____ No If yes, how many hour per week do you work?__________

Is your current job enjoyable? _____ Yes _____ No Is it unusally stressful? _____ Yes _____ No

Are you spiritual/religious? _____ Yes _____ No If yes, describe your faith or belief: _____________

____

What are some of your strengths? ____

What do you consider some of your weakness? __________________________________

What would you like to accomplish during your time in therapy? ______________________

____

How did you hear about me: ____

Health Information

Rate your physical health? _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very good

List any specific health problems you are currently experiencing: _______________________

____

Do you currently take prescription medication? _____ Yes _____ No If yes, please list: __________

____

How often do you exercise: _______ Type of exercise you participate in: ____________________

Do you have chronic pain? _____ Yes _____ No If yes, describe ____________________

Have you had significant life change? _____ Yes _____ No If yes, describe ____________________

Stressful event? _____ Yes _____ No If yes, describe ____________________

Tramatic event? _____ Yes _____ No If yes, describe ____________________

Do you drink alcohol more than once a week? _____ Yes _____ No

Do you engage in recreational drug use? _____ Yes _____ No

Are you in a romantic relationship? _____ Yes _____ No If yes, for how long? ____________________

On a scale of 1 - 10 (with10 being amazing), how would you rate your relationship? ________________

Over the last 2 weeks how often have the following bothered you:	Not at all	Several days	More than 1/2	Most every day
Little Interest/pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling/staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you have let yourself or family down	0	1	2	3
Trouble concentrating on things like reading or watching television	0	1	2	3
Moving/speaking so slowly or being so fidgety/restless that other people notice	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Add columns				
Total				

If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	
	Somewhat difficult	
	Very difficult	
	Extremely difficult	

Have you received mental health services before? _____ Yes _____ No If yes, list previous therapists/ practitioners: ____________________

Were you ever prescribed psychiatric medication? _____ Yes _____ No If yes, please list: __________

____

Family History

If there is a family history, indicate the relationship to you (father, grandmother, uncle, etc.)

Alcohol/Substance Abuse _____ Yes _____ No ______________________________

Anxiety _____ Yes _____ No ______________________________

Depression _____ Yes _____ No ______________________________

Domestic Violence _____ Yes _____ No ______________________________

Eating Disorders _____ Yes _____ No ______________________________

Obesity _____ Yes _____ No ______________________________

Obsessive Compulsive Behavior _____ Yes _____ No ______________________________

Schizophrenia _____ Yes _____ No ______________________________

Suicide Attempts _____ Yes _____ No ______________________________

Please bring completed form to your first session. Information provided here is protected confidential information.