INTAKE FORM

Cort Gravengood Psychotherapy and Counseling

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If you would like to fill this form out now and send it back, we can then make an appointment at your convenience. If you'd prefer to complete it in the office with my guidance, then please call to make an appointment.

Name______________________________________ **Date**_________________________

Parent/Legal Guardian (if under 18):____

Address____

____

Phone (Cell)___________________________ (Home)____________________________

Date of Birth______________ **Gender**____________ **Marital Status**________________

____

Most Pressing Issue____

____

____

What would you like to accomplish out of your time in therapy?

____

____

____

Previous Treatment (*Place, Duration & Year*)

1)____

2)____

3)____

Primary Care Doctor (M.D.)

Name____________________________ **Office Phone:**___________________________

Referred by (if any):____

Physical and Emotional Levels of Interest

Physical Conditions	Poor	Unsatisfactory	Satisfactory	Good
1) Overall Health	_____	______________	___________	______
2) Sleeping Habits	_____	______________	___________	______
3) Appetite	_____	______________	___________	______
4) Depression Levels	_____	______________	___________	______
5) Anxiety Levels	_____	______________	___________	______
6) Living Conditions	_____	______________	___________	______
7) Social Levels	_____	______________	___________	______

Present Medications (Name and Dosage)

1)____

2)____

3)____

4)____

5)____

Family Mental Health History: In the section below, 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 (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
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	_________________________