ARIEL BLAU
REGISTERED SOCIAL WORKER #830915 - OCSWSSW
PSYCHOTHERAPY

PSYCHOTHERAPY INTAKE

NAME:		
AGE:	DOB:	EMAIL:
Telephone: □Cell		Can we leave a confidential message? □No □Yes
□Home		Can we leave a confidential message? □No □Yes
Address		
How did you find us:	□ Provider □Friend/Colleague □Psychology Today □Website:	

REASON FOR SEEKING TX:

LEVEL of DISTRESS (0 to 10): 0 1 2 3 4 5 6 7 8 9 10 (circle)

How does this affect (0 No effect to 10 maximum effect) your:
□Family__/10 □Health___/10 □Social Life___/10 □Relationship___/10 □Work___/10 □Other:

CURRENT SYMPTOMS: *(Please check any symptoms present, Provide a level of intensity)*

☐ Loss of interest ___/10	☐ Change in sex drive ___/10 (+) (-)	☐ Sadness/Grief ___/10
☐ Low energy ___/10	☐ Anxiety ___/10	☐ Bad Dreams Repeating___/10
☐ Memory problems ___/10	☐ Fear/Scared ___/10	☐ Intrusive Thoughts ___/10
☐ Increased Fatigue ___/10	☐ Excessive worry ___/10	☐ Increase in Stress ___/10
☐ Low mood ___/10	☐ Avoidance/Isolation___/10	☐ Hallucinations ___/10
☐ Crying spells ___/10	☐ Panic Attacks ___/10	☐ Suspiciousness ___/10
☐ Feeling Guilty ___/10	☐ Excessive energy ___/10	☐ Unable to enjoy ___/10
☐ Hopelessness ___/10	☐ Impulsivity ___/10	☐ Confused/Foggy ___/10
☐ Concentration ___/10	☐ Risky behavior ___/10	☐ Existential Crisis ___/10
☐ Decision Problems ___/10	☐ Increased irritability ___/10	☐ Burn-out ___/10
☐ Change in appetite ___/10 (+) (-)	☐ No need for sleep ___/10	☐ Overwhelmed ___/10
☐ Change in Sleep ___/10 (+) (-)	☐ Racing thoughts ___/10	☐ Overloaded ___/10

CURRENT STRESSORS

PERSONAL STRENGTHS

SUPPORT SYSTEM

YOUR GOALS FOR TREATMENT

I want less of:

I want more of:

I want the following to change:

MEDICAL

CURRENT MEDICAL CONDITIONS	CURRENT MEDICATIONS

CONFIDENTIAL QUESTIONNAIRE

HISTORY

What complications did your mother have during the pregnancy or birth? □None □Please Describe:
When you were growing up, were there any concerns with your health and development? □None □**Yes,** Describe:
Who was your caretaker? How was your relationship?
When you were growing up, were there any significant events that affected your life? □None □**Yes** Describe:

EDUCATIONAL HISTORY

Did you have any difficulties in school or with your education? □Y □N Please explain:			
Highest level of Education achieved:	Degree:	Year:	Field:

OCCUPATIONAL HISTORY

□Employed F/T □Employed P/T □Unemployed □Stay at home parent □Gov. Support □Retired	
Place of work:	Position:
What is the best thing about your work?	How stressful is your work right now?

TRAUMA/LOSSES

TRAUMA HISTORY □None □Past □Recent □Neglect/Abandonment □Physical Abuse □Psychological Abuse □Sexual Abuse □Domestic Violence □War □Immigration □Discrimination □Medical □Accident	Do you want help with this? □Y □N
Has anyone in your immediate family or friends died recently? Who? When?	

RELATIONSHIP HISTORY

Are you currently:	□Single □Married □Common Law □Partnered □Widowed □Divorced How long?
Describe your relationship:	
List children's names & age:	

MENTAL HEALTH TREATMENT HISTORY

Counselling/Psychotherapy □No □Yes If yes, please explain:
Psychiatric Hospitalization □No □Yes If yes, please explain:

MENTAL HEALTH PROBLEMS IN FAMILY MEMBERS

Condition	Who	Relationship	Condition	Who	Relationship

SUBSTANCE USE:	□None □Past □Recent	Do you want help with this? □Y □N
SUICIDE Ideation/Fantasizing	□None □Past □Recent	Do you want help with this? □Y □N
SUICIDE Plans/ Intent	□None □Past □Recent	Do you want help with this? □Y □N
SUICIDE Attempts	□None □Past □Recent	Do you want help with this? □Y □N
SELF-HARM	□None □Past □Recent	Do you want help with this? □Y □N
VIOLENT BEHAVIOR	□None □Past □Recent	Do you want help with this? □Y □N
DISORDERED EATING	□None □Past □Recent	Do you want help with this? □Y □N
GAMBLING/GAMING/PORN	□None □Past □Recent	Do you want help with this? □Y □N
Please explain any above:		

ANYTHING ELSE THAT we need to know to give you the best service:

Completed by: _____ Signature: _____ Date: _____