Dr. Samuel Mikail

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Relationship Status:
□ Never Married □ Dating □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

If in a relationship/marriagey, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

Please list any children (ages): _____

_____

Address: _____
(Street and Number)
_____
(City) (Province) (Postal Code)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication. We will not respond to emails that involve disclosing confidential information.

Referred by (if any): _____

Have you previously received any type of psychological or mental health services (psychotherapy, counseling, psychiatric treatment/consultation)?

□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No
Current Medications and Dosage:
_____

_____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates: _____
_____
_____

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 currently 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 currently experiencing:

_____

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

What types of exercise to you participate in _____

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

5. Are you currently experiencing marked sadness, grief or depression?

□ No □ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or any phobias?

□ No □ Yes

If yes, when did you begin experiencing this? _____

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

If yes, please describe _____

8. On average how much alcohol do you drink in a week? □ No □ Yes

9. Do you use any recreational drugs? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

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

_____

_____

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 (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	_____

11. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

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

_____
_____

12. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

13. What do you consider to be some of your strengths?

_____
_____
_____
_____

14. What do you consider to be some of your weakness?

_____
_____
_____
_____

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

_____
_____
_____