CLIENT INTAKE FORM

True To You Psychotherapy & Consulting, Inc.

Dr. Jas Tilghman, Ph.D. PSY28549

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:
__Medical Provider: _____
__Insurance Provider: _____
__Website: _____
__Psychology Today: _____
__Friend/Family: _____
__Other: _____

Have you previously received any type of mental health services? Circle: Yes No
If yes, which of the following services have you received:

__Psychotherapy
__Medication
__Outpatient Hospitalizations Inpatient Hospitalization

Please Provide:

Name of provider of facility:_____
Location:_____
Dates of treatment:_____
Reason for treatment:_____

Briefly, what brings you in today?
_____

When did your problem first start?

__Within the last: 30 days
__6-12 months
__2 years
__During adolescence
__During childhood

What areas of your life have been affected because of this problem?
_____

Are you currently experiencing overwhelming sadness, grief or depression? Circle: Yes No
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? Circle: Yes No
If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:
_____

What significant life changes or stressful events have you experienced recently?
_____

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

Family History

Where were you born? _____

Where did you grow up? _____

__City
__Suburbs
__Country

Please list your parents and siblings. Please use additional space on the back if needed:
_____

Name	Age	Relationship	Where they live now	If deceased, age and cause of death

Who did you live with while growing up? _____
Mother's occupation: _____
Father's occupation? _____

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.).

Condition	**Please circle**	**List Family Member**
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:
__Never Married
__Domestic Partner
__Married
__Separated
__Divorced -- For how long?
__Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:
_____

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship? Circle: Yes -- How long? _____ No

On a scale of 1-10 (best), how would you rate your relationship? _____
Please list any children, their names, and ages:

Name	**Age**	**Relationship**	**Name of other parent**	**If deceased, age and cause of death**

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:
Name: _____
Specialty: _____
Facility: _____
Phone, email, or Fax: _____

How would you rate your current physical health?

__Poor
__Unsatisfactory
__Satisfactory
__Good
__Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

__Poor
__Unsatisfactory
__Satisfactory
__Good
__Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

__Falling asleep
__Staying asleep
__Awakening early
__Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you exercise? _____What types of exercise do you participate in:

Are you currently experiencing any chronic pain? Circle: Yes No
If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?