KATHLEEN RAPP, LCSW
INTAKE FORM

Name ______________________________________ SSN ________________________ Today's Date _____________
Address _______________________________________ City, State Zip ____
Phones - Home ______________ Cell ______________ Work _____________ E-mail _______________________________
Birth Date _______________ Age _____ Gender M ❑ F ❑ Marital Status ______ Driv. Lic. # _________________
Emergency Contact ___________________________ Phone ____________________ Relationship ___________________
Primary Care Physician ______________________________________ Phone _________________ Fax _______________
Spouse/Partner's name _____________________ Others living with you ____
List of children:

Child's name	Age	Lives where	Useful information about your child

Occupation __________________________ Level of Education Completed _________ Religion ____________________
Employer ___________________________ Address ____
Insurance Co. ________________________ Subscriber ID ________________ Subscriber Name ____________________

How did you hear about this practice? ____

If you have you ever been treated for a *mental health issue (including substance abuse)*, please complete the following:

Date(s)	Counselor/Hospital	Focus of Treatment	Reason for Stopping

List of *current medications* (include supplements):

Medication	Dosage	Date Started	Medication	Dosage	Date Started

List of *medical conditions, handicaps, surgeries, accidents or suicide attempts*:

Date	Condition/Experience	Details	Current Status

List of *marriages and significant relationships*:

Spouse/Partner's Name	Age	Date Began	Date Ended	Reason for Separation/Divorce

For each problem/issue listed that you experience, place a check mark in the appropriate column to indicate *how often you experience the problem or issue*. Include problems/issues that apply to you even if you don't intend to work on them in therapy.

	--------------- FREQUENCY ---------------		
Problem/Issue	**None/little of the time**	**Some of the time**	**Most or all of the time**
Wake at night or early morning and unable to return to sleep			
Very restless sleep			
Unable to fall asleep			
Sleeps a lot			
Bad dreams or nightmares			
Fatigue or lack of energy			
Decreased sex drive			
Unable to enjoy life; have lost zest for life			
Have withdrawn from others			
Feeling isolated and lonely			
Lack of motivation			
Feelings of inferiority			
Loss of appetite			
Thoughts of hurting yourself/episode(s) of self-harm			
Thoughts of suicide			
Thoughts of hurting someone else			
Personal or family violence			
Loss of appetite			
Memory problems; forgetfulness; inability to concentrate			
Irritable or easily frustrated			
Sadness or hopelessness			
Increased energy			
So happy or energetic that people say I'm "hyper" or "manic"			
Decreased need for sleep			
Increased sex drive			
Sudden episodes of nervousness or panic			
Fear of losing self-control			
Palpitations or rapid heartbeat			
Shortness of breath			
Tense and anxious all day			
Very anxious in social situations			
Recurring troubling thoughts, images or impulses			
Repetitive behaviors (such as hand-washing, checking, ordering)			
Very confused, strange or bizarre thoughts			
Hallucinations, hearing voices, seeing things that aren't really there			
Very peculiar experiences that others do not understand			
Angry outbursts			
Feel like you're ready to explode			
Use of drugs or alcohol			
Use of pornography			
Extra-marital affairs			
Overeating			
Anorexia and/or bulimia			
Problems with gambling			

For each item listed, place a check mark in the appropriate column to indicate how often you are involved with each of the following:

----------------------- FREQUENCY -----------------------

Involvement	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Getting together with friends					
Family activities					
Church/temple activities					
Clubs and organizations					
Exercise					
Yoga					
Meditation					

Please describe any past or present challenges with the following:

Issue	**Description of Challenges**
Work/Career	
Finances	
Marriage/ Partnership	
Friendships	
Legal	
School	
Childhood (neglect/abuse)	

Was school difficult for you? Yes ❑ No ❑ If yes, please describe ____

How well did your parents get along with each other? ____

How well did you get along with your parents? ____

If there is anything else you would like me to know or you think might help our work together, please include it here:

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The information in this document will remain confidential. Providing this information is voluntary.

By signing below, I hereby consent to treatment with Kathleen Rapp, LCSW.

Signature ____ Date ______________________