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INITIAL INTAKE

PERSONAL INFORMATION

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

DOB: _____ Age: _____ Gender: _____

Address: _____

Home Phone: _____ May we leave a message? Yes No

Phone: _____ May we leave a message? Yes No

Email: _____ May we leave a message? Yes No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Marital Status:

Never Married

Domestic Partnership

Married

Separated

Divorced

Widowed

Referred By (if any): _____

HISTORY

Have you previously received any type of mental health service (psychotherapy, psychiatric services, etc.)? No Yes

Previous practitioner & dates: _____

Are you currently taking any prescription medication? Yes No

If yes, please list medication and prescribing physician:

GENERAL AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle one)

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 one)

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you exercise & what type of exercise?

4. List difficulties you experience with your appetite or eating problems:

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

No Yes

For approximately how long? _____

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

No Yes

When did you begin experiencing symptoms?

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

If yes, please describe:

8. Do you drink alcohol? No Yes

How many drinks per week?

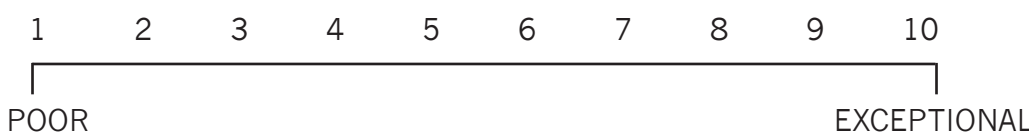
9. How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes

If yes, how long? _____

On a scale of 1-10 how would you rate your relationship? Please circle one.



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

FAMILY MENTAL HEALTH HISTORY

Please 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, 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	_____

ADDITIONAL INFORMATION

1. Are you currently employed? No Yes

If yes, what type of job do you do?

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

2. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

3. What are some of your strengths?

4. What are some of your weaknesses?

5. What are some of your goals for your time in therapy?
