Revive Therapeutics
Repair · Recover · Thrive

(860) 494-3800

INTAKE FORM

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

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

Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Birth Date:_____/_____/_____ Age:_____ Gender: O Male O Female

Address:_____
(Number and Street) (City) (State) (Zip)

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

Cell/Other Phone:_____ May we leave a message? O Yes O No

E-mail:_____ May we e-mail you? O Yes O No

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

Referred by (if any):_____

Insurance Provider Name:_____Ind. ID#:_____ Group ID#:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1) How would you describe your current physical health? Please list any specific health problems and the names of treatment providers):

_____

_____

2) Please describe any mental or behavioral health therapy you may have received in the past?

_____

3) How would you describe your current sleeping habits?

_____

4) How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

5) Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

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

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

8) Please describe any history of alcohol or drug use:

_____

_____

9) Have you previously received any substance abuse treatment services?
O No
O Yes, previous therapist/hospital/facility: _____

10) Are you currently taking any prescription medication?
O No
O Yes
Please list: _____

11) Have you ever been prescribed psychiatric medication? O Yes O No

FAMILY AND INTIMATE RELATIONSHIP HISTORY

1) Are you currently in a romantic relationship? O No O Yes
   If yes, for how long? _____
   On a scale of 1-10, how would you rate your relationship? _____
   Please list any children/age: _____
   Please describe any relevant information regarding past intimate relationships:

   _____

   _____

2) Please describe any family history of the following:
   Alcohol/Substance Abuse/Mental health problems (including diagnosis) _____

   _____

   _____

   Suicide Attempts: _____

   Additional Notes: _____

   _____

ADDITIONAL INFORMATION

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

   _____

   _____

2) Are you currently employed? O No O Yes
   If yes, what is your current employment situation?

   _____

3) What do you consider to be your strengths? _____

   _____

   _____

4) What do you consider to be your weaknesses? _____

_____

_____

5) What would you like to accomplish during your time in therapy? _____

_____

_____

_____

_____