Akiho Tanaka, PhD, LLC
Intake Form

Please fill out this form as completely and legibly as possible, and bring it to your first session. The information you provide here is confidential.

Name:_____
(last) (first) (middle initial)

Date of Birth: _____/____/_____ Birthplace: _____
(month) (date) (year)

Age:_____ Racial/ethnic identity:_____

Gender:_____ Sexual orientation:_____

Highest education level completed:_____

Relationship status: __Single __Partnered __Married __Separated __Divorced __Widowed

Current partner's first name, age, years in relationship:

_____

Please list children's gender/age: _____

_____

Address: _____
(street and number)

_____
(city) (state) (zipcode)

Home Phone: _____

May I leave you a message: __Yes __No

Cell/Other Phone: _____

May I leave you a message: __Yes __No

Email: _____

May I e-mail you? __Yes __No

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

Would you like to receive **e-mail** appointment reminders? __Yes __No

Referred by (if any): _____

May I thank this person (if referred)? Yes__ No__

Emergency contact: _____
(name & relationship to you) (phone number)

Primary care physician & phone number: _____

_____

Have you previously received psychological, psychiatric, or counseling services?

No__

Yes__

If yes, please list the previous therapist/practitioner, when you were seen (i.e., Feb 2002- April 2004), and the nature of the issues addressed: _____

_____

_____

_____

Have you ***ever*** been prescribed psychiatric medication?

No__

Yes__

If yes, list and provide dates: _____

_____

Have you ***ever*** been hospitalized for psychological reasons?

No__

Yes__

If yes, please give the dates and the nature of the difficulty at the time:

_____

_____

GENERAL PHYSICAL AND MENTAL HEALTH INFORMATION:

1. Rate your **current** physical health (*please circle*):

Poor Unsatisfactory Satisfactory Good Very good

Please list any significant past or current medical issues:

_____

_____

_____

_____

Please list any medications you **currently** take (*prescriptions and over-the-counter medications*) and the dosage of each:

_____

_____

_____

_____

2. Rate your **current** sleep quality (*please circle*):

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep issues you are **currently** experiencing:

_____

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

What type of exercise do you engage in: _____

4. Please list any **current** difficulties you are having with your appetite or eating patterns:

_____

_____

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

No__

Yes__

If yes, when did it start? _____

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

No__

Yes__

If yes, when did you begin experiencing this? _____

7. Are you **currently** experiencing chronic pain?
Yes__
No__
If yes, please describe: _____

8. On average, how many alcoholic beverages do you consume per week? _____

9. How often do you engage in recreational drug use? (*please circle*)
Daily Weekly Monthly Rarely Never

10. If you are currently in a romantic relationship, how would you rate the quality of your relationship on a scale of 1-10 (*1=terrible, 10=excellent*)? _____

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

_____

Have you ever experienced (*please circle current and/or past if it applies to you*):

Depressed Mood	current	past
Mood Swings	current	past
Anxiety	current	past
Social Anxiety	current	past
Panic Attacks	current	past
Phobias	current	past
Obsessions	current	past
Compulsions	current	past
Trauma	current	past
Hallucinations	current	past
Anger Management Issues	current	past
Alcohol/Substance Abuse	current	past
Frequent Health Complaints	current	past
Sleep Problems	current	past
Eating Disorder	current	past

Body Image Concerns	current	past
Grief or Loss	current	past
Identity Issues	current	past
Family Issues	current	past
Relationship Difficulties	current	past
Work Issues	current	past

FAMILY MENTAL HEALTH HISTORY:

If any family members have had any history of the following, please indicate their relationship to you in the space provided (*e.g., father, mother, grandfather, grandmother, uncle, aunt, etc.*).

List Family Member

Alcohol/Substance Abuse
Anxiety
Depression
Eating Disorder
Obsessive Compulsive Disorder
Personality Disorder
Post-traumatic Stress Disorder
Schizophrenia
Suicide Attempt(s)

ADDITIONAL INFORMATION:

1. Are you currently employed?
No__
Yes__
If yes, please list your current occupation and employer:

_____

Are you happy with your current work situation? Any work-related stressors?

_____

_____

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

_____

3. What do you consider to be your strengths? What do you love about yourself?

_____
_____
_____
_____

4. In your own words, what are the main concerns that you want to address in therapy?

_____
_____
_____
_____
_____
_____

5. Therapy can be a powerful force for change. In order to get the most out of therapy, it is important to have clear and specific goals. What would you like to accomplish in therapy?

_____
_____
_____