Vritti Integrative Psychotherapy

Fremont
3417 Evanston Ave N
Suite 304
Seattle Wa 98103

West Seattle
2600 SW Barton St
Suite A24
Seattle Wa 98126

Intake Form

Please provide the following information and answer the questions below. Information you provide here is protected as confidential information.

Name _____

Name of parent / guardian (if client is under 18 years old)
_____

Address
_____
_____

Phone (Home) _____
OK to leave message? Y / N

Phone (Cell) _____
OK to leave message? Y / N

Phone (Work) _____
OK to leave message? Y / N

Email _____

OK to email you? Y / N
Please note: email correspondence is not considered to be a confidential form of communication.

Emergency Contact Information

Who can I contact in the event of any emergency?

Name _____

Address

_____

_____

_____

Emergency Contact Phone _____

Client Personal Information

Birth Date _____ / _____ / _____
Age _____

Gender M / F **Identify as** _____

Marital Status

Never Married ___
Domestic Partnership ___
Married ___
Separated ___
Divorced ___
Widowed ___

Please list any children below:

Name _____
Age ____ **Gender** ____
Name _____
Age ____ **Gender** ____

Name _____
Age ____ **Gender** ____

Name _____
Age ____ **Gender** ____

Medical History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.?)

_____No _____Yes

Previous therapist / practitioner

_____

No information is ever shared between practitioners without your prior written consent.

Health and Medical Background

Name of Primary Care Physician

_____

Physician's Address

_____

_____

_____

Physician's Phone _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One)
YES / NO

Please sign here for either answer

_____

Date of last medical evaluation _____
Date of next appointment _____

Are you currently taking any prescription medication?
_____ Yes _____ No

Medication Prescribed for:

_____
Date _____

Medication Prescribed for:

_____
Date _____

Have you ever been prescribed psychiatric medication?
_____ Yes _____ No

Medication Prescribed for psychiatric medication:

_____
Date _____

Have you ever considered suicide in connection to your current problem? (Circle One) YES / NO
If so, please give a brief description with dates

_____
_____
_____

Have you ever considered suicide in the past? (Circle One) YES / NO
If so, please give a brief description with dates

_____
_____
_____

Have you attempted suicide recently or in the past?
(Circle One) YES / NO
If so, please give a brief description with dates

_____
_____
_____

Have you had any homicidal thoughts recently or in regard to your current problem? (Circle One) YES / NO
If yes, please explain

_____
_____
_____

Have you ever considered homicide in the past?
(Circle One) YES / NO
If yes, please explain

_____

_____

_____

Have you ever engaged in self-harm behavior such as cutting and/or self-mutilation Current and/or in the past?
Date of last episode_____

Thoughts

Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.
_____I sometimes feel that forces outside of me control me.
_____I sometimes feel that other people control my thoughts.
_____I sometimes have the same thought over and over and cannot control it.
_____I sometimes feel that someone is out to hurt me or do something against me.
_____I am sometimes unable to control my behavior.
If yes, please explain
_____

_____

How would you rate your current physical health?

____ Poor
____ Unsatisfactory
____ Satisfactory
____ Good
____ Excellent

Please list any specific health problems you are currently experiencing:

_____
_____
_____
_____

How would you rate your current sleep habits?

_____ Poor
_____ Unsatisfactory
_____ Satisfactory
_____ Good
_____ Excellent

Please list any specific sleep problems you are currently experiencing:

_____
_____
_____
_____

How many times per week do you generally exercise?

_____

What types of exercise do you participate in?

_____

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

_____

_____
_____
_____

Are you currently experiencing overwhelming sadness, grief or depression? ____ No ____ Yes

If yes, for approximately how long?

_____
_____

Are you currently experiencing anxiety, panic attacks or have any phobias? ____ No ____ Yes

If yes, when did you begin experiencing this?

_____
_____

Are you currently experiencing any chronic pain?
____ No ____ Yes

If yes, please describe:

_____
_____
_____

How often do you drink alcohol?

____ Daily
____ Weekly
____ Monthly
____ Infrequently
____ Never

How often do you engage in recreational drug use?

_____ Daily
_____ Weekly
_____ Monthly
_____ Infrequently
_____ Never

Are you currently in a romantic relationship?
_____ No _____Yes

If yes, for how long?
_____
_____

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

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

Family Mental Health History

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.)

Alcohol / Substance Abuse ___ No ___ Yes
_____

Anxiety ___ No ___ Yes
_____

Depression ___ No ___ Yes
_____

Domestic Violence ___ No ___ Yes
_____

Eating Disorders ___ No ___ Yes
_____

Obesity ___ No ___ Yes
_____

Obsessive/Compulsive Behavior ___ No ___ Yes
_____

Schizophrenia ___ No ___ Yes
_____

Suicide Attempts ___ No ___ Yes
_____

Additional Information:

Are you currently employed? ____ No ____ Yes

If yes, what is your currently employment situation?

_____

_____

Do you enjoy your work? ____ No ____ Yes

Is there anything stressful about your current work? If so, please describe:

_____

_____

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

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 weaknesses?

_____

_____

_____

_____

What would you most like to accomplish with your time in therapy?

Please list your therapy goals:

_____
_____
_____
_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____
_____
_____
_____
_____

How did you hear about me?

_____

Client Signature (or Parent / Guardian if client is under 18)

_____

Today's Date

_____