Ashley Davis Bush, LICSW
Intake Form

Please provide the following information and answer the questions below. All information will remain confidential.

Today's Date _____________

Personal Information

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

Date of Birth: _____ / _____ / _____ Age: _____ Gender: ❑ Male ❑ Female

Address: ____
(Street and #) (City) (State) (Zip)

Home Phone: ________________________ May I leave a message? ❑ Yes ❑ No

Cell/Other Phone: ____________________ May I leave a message? ❑ Yes ❑ No

Email Address: ____ May I email you? ❑ Yes ❑ No
*Please note: Email correspondence is not considered confidential communication

Emergency Contact Information

Name:____________________________ Relationship: _______________________________

Home Phone: _____________________________ Alternate Phone: ___________________________

Insurance Information

Insurance Policy name and number: ____

Subscriber name and date of birth: ____

Referred by (if any):____

Are you currently employed? ❑ No ❑ Yes

If yes, what is your current employment situation? ____

____

Do you enjoy your work? ____

Is there anything stressful about your current work? _______________________________________

____

____

Do you consider yourself to be spiritual or religious? ❑ No ❑ Yes
If yes, describe your faith or belief: ____

____

What was your religious upbringing? ____

Mark your highest level of formal education completed:
❑ grade school ❑ high school ❑ AA ❑ BA/BS ❑ MA/MS ❑ PhD/MD
Other _______________

Marital Status:
❑ Never Married ❑ Domestic Partnership ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Please list any children:

Name	Age	Biological	Adopted	step	Deceased
		❑	❑	❑	❑
		❑	❑	❑	❑
		❑	❑	❑	❑
		❑	❑	❑	❑
		❑	❑	❑	❑

Who currently lives in your home? ____

____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
❑ No ❑ Yes Previous therapist/practitioner: ______________________________________
Dates: from ________ to ________
Describe your experience: ____

____

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____

What do you consider to be some of your personal strengths? ____________________________

____

____

____

What are some of your hobbies and interests?______________________________________

____

What do you consider to be some of your personal weaknesses? ______________________

____

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____

What would you like to accomplish out of your time in therapy? ____________________

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____

General Health and Mental Health Information

How would you rate your current physical health?

❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very Good

Please list any specific health problems you are currently experiencing:

____

How would you rate your current sleeping habits? (please circle)

❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very Good

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: ____

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

If yes, please list and provide dates: ____

____

Are you currently taking prescription medication? ❑ No ❑ Yes
If yes, please list and provide dates: ____

____

Do you drink alcohol more than three times a week? ❑ No ❑ Yes

How often do you engage 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? ____________

What significant life changes or stressful events have you experienced recently:

____

Family Mental Health History

In this section please identify if there is a family history of any of the following diagnoses. If yes, please indicate the family member's relationship to you in the space provided.

Diagnoses		Family Member
Alcohol/Substance Abuse	❑ No ❑ Yes	
Anxiety	❑ No ❑ Yes	
Depression	❑ No ❑ Yes	
Domestic Violence	❑ No ❑ Yes	
Eating Disorder	❑ No ❑ Yes	
Obesity	❑ No ❑ Yes	
Obsessive Compulsive Behavior	❑ No ❑ Yes	

Schizophrenia	❑ No ❑ Yes	
Suicide Attempts	❑ No ❑ Yes	

Family of Origin

Is your father living? ❑ No ❑ Yes Where does he reside? ____________________
Rate your relationship with your father on a scale from 1-10: __________
If deceased, what year? __________ How old were you at the time? ____________

Describe your current or past relationship with him: ___________________________________

____

____

Is your mother living? ❑ No ❑ Yes Where does she reside? ____________________
Rate your relationship with your mother on a scale from 1-10: __________
If deceased, what year? __________ How old were you at the time? ____________

Describe your current or past relationship with her: ___________________________________

____

____

Parents divorced? ❑ No ❑ Yes If yes, what year? _______ How old were you? _______

Do you have step-parents? ❑ No ❑
If yes, describe your relationship with them: ____

____

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If raised by someone other than your birth parents, describe the situation: ________________

____

____

Where were you born? __________________________ How long were you there? _________

Please list siblings and their ages: ____

____

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Did you experience a significant childhood trauma? ❑ No ❑ Yes If yes, describe: __________

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Is there anything else about you that you'd like me to know? __________________________

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