



*Zen for Change*  
Body, Mind, & Spirit Healing

# INTAKE FORM

*Please provide the following information and answer the questions below. Please note that all information you provide here is protected as confidential information.*

Major psychological concern:

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

No  Yes, previous therapist/practitioner:

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# INTAKE FORM

Are you currently taking any prescription medication?     Yes  No

Please list: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been prescribed psychiatric medication?     Yes  No

Please list and provide dates: \_\_\_\_\_  
\_\_\_\_\_

Have you ever experienced significant trauma?     Yes  No

Please explain: \_\_\_\_\_  
\_\_\_\_\_

How would you rate your current physical health? (please circle)

Poor    Unsatisfactory    Satisfactory    Good    Very good

Please list any specific health problems you are currently experiencing:

\_\_\_\_\_  
\_\_\_\_\_



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# INTAKE FORM

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

Poor Unsatisfactory      Satisfactory      Good      Very good

Please list any specific sleep problems you are currently experiencing:

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How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise to you participate in:

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

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# INTAKE FORM

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

If yes, for approximately how long?

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

If yes, when did you begin experiencing this?

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Are you currently experiencing any chronic pain?  No  Yes

If yes, please describe?

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Do you drink alcohol more than once a week?  No  Yes

Explain:

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# INTAKE FORM

How often do you engage recreational drug use?

- Daily
- Weekly
- Infrequently

Explain:

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Are you currently in a romantic relationship?  No  Yes

If yes, for how long?

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How satisfied are you in this relationship? How long have you've been together?

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Do you have any children? Ages? Relationship with them?

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# INTAKE FORM

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

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**Family History:**

Father:

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Mother:

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Sibling:

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### 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 \_\_\_\_\_

Anxiety / Depression \_\_\_\_\_

Domestic Violence \_\_\_\_\_

Eating Disorders / Obesity \_\_\_\_\_

Obsessive Compulsive Behavior \_\_\_\_\_

Schizophrenia \_\_\_\_\_

Suicide Attempts \_\_\_\_\_

### Additional Information:

Are you currently employed? Or in school?  No  Yes

If yes, what is your current employment/school situation:

\_\_\_\_\_

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

\_\_\_\_\_



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# INTAKE FORM

Do you consider yourself to be spiritual or religious?

No  Yes If yes, describe your faith or belief:

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Have you ever had any legal problems? Please explain:

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What do you consider to be some of your strengths?

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What do you consider to be some of your weakness?

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# INTAKE FORM

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

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**INTAKE FORM**

**Additional Intake Notes:**

Lined area for taking notes, consisting of multiple horizontal lines.

Estefanía Simich, MA, NCC, LCPC, CST

Date