Estefanía Simich, MA, NCC, LCPC, CST
Baltimore, MD
PHONE: (443) 326-9018

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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:

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

☐ No ☐ Yes, previous therapist/practitioner:

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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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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:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

_____

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

_____

_____

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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?

_____

_____

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

Explain:

_____

_____

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How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Infrequently

Explain:

Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, for how long?

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

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

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

Family History:

Father:

Mother:

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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Do you consider yourself to be spiritual or religious?

☐ No ☐ Yes If yes, describe your faith or belief:

Have you ever had any legal problems? Please explain:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

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

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INTAKE FORM

Additional Intake Notes:

Estefanía Simich, MA, NCC, LCPC, CST Date