# Intake Form
# Davida Joy Cohen, LMSW, ACSW

1) Name ________________________ Age_________ Birthdate ________________ Date:::::::::::::

Address ______________________________________________ Email _________________________________

City _________________________________________________ State _____________ Zip _______________

Home Phone ________________Work Phone _____________________Cell Phone:_______________

2) If under 18 years of age, name of legal guardian,address and phone number:

________________________________________________________________________________

3) Occupation _________________________________ Employer _____________________________________

________________________________________ Length of time at current job: ______________

Postiton: _______________________________________

4) Marital Status ________________________ Name of Spouse/Partner ________________________

How Long Have Both of You Been Together? _______________

Chlildren: Name/Age________________________

Name /Age________________________________

Name /Age_________________________________

Name/Age__________________________________

5) Religion _____________________________

6) Emergency Contact Name and Relationship _________________________________ Phone _____________

Address _______________________________________ City ___________________ State ______Zip ________

&) Do You Smoke?__________How Much Per day?__________
Do You Drink?________ How Much? _________Howoften?________
Do You Use Drugs?__________If yes, what kinds? ________________________How often?_________________

8.Last Medical Examination_________________Reason _________________________________________

Are You Now Under Doctors' Care?__________If yes, Doctors name(s): __________________________

Reason for Doctor's Care: ________________________________________________________________________

___________________________________________________________________

Are You Taking Any Medication?_____________If yes, which medications? _______________________________

_________________________________

Reason for Medications: ________________________________________________________________________

Have You Ever Been Hospitalized for a Physical Illness? Describe:_______________________________________

_____________________________________________________________________________________

9. Have you ever been Hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe:

Any Previous Therapy/Counseling?

When and Number of Sessions:

Type of Therapy/Counseling:

10.Who referred you to DavidaCohen?

11.What do you Wish to Achieve with Therapy?

**Check Any of the Following That May Apply to You:**

- [ ] Headache
- [ ] Dizziness
- [ ] Fainting Spells
- [ ] No Appetite
- [ ] Over-Eating
- [ ] Stomach Trouble
- [ ] Bowel Disturbances
- [ ] Always Tired
- [ ] Always Sleepy
- [ ] Unable To Relax
- [ ] Insomnia
- [ ] Recurrent Dreams
- [ ] Nightmares
- [ ] Hallucinations
- [ ] Inferiority Feelings
- [ ] Feel Tense
- [ ] Feel Panicky
- [ ] Fears and Phobias
- [ ] Obsessions
- [ ] Depressed
- [ ] Suicidal Ideas
- [ ] Take Tranquilizers
- [ ] Alcoholism
- [ ] Dangerous Drugs
- [ ] Allergy
- [ ] Asthma
- [ ] Angry
- [ ] Sexual Problems
- [ ] Shy With People
- [ ] Can't Make Friends
- [ ] Afraid Of People
- [ ] Home Conditions Bad
- [ ] Unable To Have A Good Time
- [ ] Always Worried About Something
- [ ] Don't Like Weekends/Vacations
- [ ] Can't Make Decisions
- [ ] Over-Ambitious
- [ ] Financial Problems
- [ ] Gambling
- [ ] Job Problems
- [ ] Can't Keep A Job
- [ ] Other:please List:

*Please fill out and email or print out and bring to your first session.