FABIANA FRANCO PH.D. LLC
CLINICAL AND CONSULTING SERVICES

Intake Form

Please provide the following information and answer the questions below.

- Information you provide in this form is protected as confidential information.

Name	First name: Middle name: Last name:
Name: of parent/guardian (if under 18 years):	First name: Middle name: Last name:
Date of Birth:	Month: / Day: / Year:
Age:	
Gender:	
Marital Status:	❑ Never Married ❑ Domestic Partnership ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Children (please include age):	
Address:	Street and Number: City and State: Zip Code:
Home Phone:	( ) - May we leave a message? ❑ Yes / ❑ No
Cell/Other Phone:	( ) - May we leave a message? ❑ Yes / ❑ No
Email:	May we send you email? ❑ Yes / ❑ No - Email is not considered a confidential medium of communication.
Referred by (if any):	
Have you previously received mental health services (psychotherapy, psychiatric services, etc.)?	❑ No ❑ Yes. Please list previous therapist/practitioner:
Are you currently taking any prescription medication?	❑ No ❑ Yes. Please list:

Have you ever been prescribed psychiatric medication?	❑ No ❑ Yes. Please list and provide dates:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits?

❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. Exercise

How many times per week do you generally exercise? ____
What types of exercise to you participate in: _____

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

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?

❑ No ❑ Yes
If yes, for approximately how long?
_____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

❑ No ❑ Yes

If yes, when did you begin experiencing this?

_____

7. Are you currently experiencing any chronic pain?

❑ No ❑ Yes

If yes, please describe:_____

8. Do you drink alcohol more than once a week?

❑ No ❑ Yes

9. How often do you engage recreational drug use?

❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

10. 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?

11. 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 there is a family history, please indicate your relationship to the family member (father, mother, sibling, child, grandmother, uncle, etc.).

Issue	History	Relationship to you
Alcohol/Substance Abuse	❑ No ❑ Yes	
Anxiety	❑ No ❑ Yes	
Depression	❑ No ❑ Yes	
Domestic Violence	❑ No ❑ Yes	
Eating Disorders		
Obesity	❑ No ❑ Yes	
Obsessive Compulsive Behavior	❑ No ❑ Yes	
Schizophrenia	❑ No ❑ Yes	
Suicide Attempts	❑ No ❑ Yes	

ADDITIONAL INFORMATION:

1. 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?

_____

2. Do you consider yourself to be spiritual or religious?

❑ No ❑ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

5. What would you like to accomplish in therapy?

_____

_____

_____