Pat Ahl, LPCC, NCC

Intake Form

Please provide the following information and answer the questions below.
Please note: Information you provide here is protected as confidential information.

Today's Date: ____/____/_____

Name: (Last, First, Middle Initial) _____

Birth Date: ____/____/_____ **Age:** ____ **Gender:** ____ Male ____ Female

Marital Status: ____ Never Married ____ Domestic Partnership ____Married
____ Separated ____Divorced ____Widowed

Please list any children/age:

Address (Street and Number, City, State, Zip):

Phone Numbers (Please indicate if we may leave a message):

Home: _____ Message: ____ Yes ____ No

Cell: _____ Message: ____ Yes ____ No

Work: _____ Message: ____ Yes ____ No

May we email you? If yes, please provide your email address:

Please note: Email and texting correspondence are not considered to be a confidential medium of communication.

How did you hear about us?

136 Northwoods Blvd • Worthington, OH 43235
Office: (614) 529-8100 • Fax: (614) 529-8517
www.PatAhl.com

Have you previously received any type of mental health services such as psychotherapy or psychiatric services? ____ Yes ____ No

If yes, please provide the name of previous therapist/practitioner, and what did you like or dislike about the experience?

Are you currently taking any prescription medication? ____ Yes ____ No

If yes, please list:

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

If yes, please list and provide dates:

General Health and Mental Health Information

How would you rate your current physical health? (Check one)

____Poor ____Unsatisfactory ____Satisfactory ____Good ____Very Good

Please list any specific health problems are you are currently experiencing:

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How would you rate your current sleeping habits? (Check one)

____Poor ____Unsatisfactory ____Satisfactory ____Good ____Very Good

Please list any specific sleep problems are you are currently experiencing:

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? ____ Yes ____ No

If yes, for approximately how long? _____

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

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? ____ Yes ____ No

If yes, please describe: _____

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

Do you engage in recreational drug use? ____ Yes ____ No

If yes, how often? ____ Daily ____ Weekly ____ Monthly ____ Infrequently ____ Never

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

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?

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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	____ Yes ____ No	Family Member: _____
Anxiety	____ Yes ____ No	Family Member: _____
Depression	____ Yes ____ No	Family Member: _____
Domestic Violence	____ Yes ____ No	Family Member: _____
Eating Disorders	____ Yes ____ No	Family Member: _____
Obesity	____ Yes ____ No	Family Member: _____
OCD	____ Yes ____ No	Family Member: _____
Schizophrenia	____ Yes ____ No	Family Member: _____
Suicide Attempts	____ Yes ____ No	Family Member: _____

Have you ***ever*** attempted suicide or harmed yourself in ***any way***? ___ Yes ___ No

Have you had any thoughts in the past few ***days or weeks*** of suicide or harming yourself in ***any way?*** ___ Yes ___ No

Are you ***currently*** thinking about suicide or harming yourself in ***any way?*** ___ Yes ___ No

Are you having ***any*** thoughts about harming ***anyone else*** in ***any way?*** ___ Yes ___ No

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Additional Information

Are you currently employed? ____ Yes ____ No

If yes, please provide the name and address of your employer:

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

Do you consider yourself to be spiritual or religious? ____ Yes ____ No

If yes, please describe your faith or belief:

What do you consider some of your strengths?

What do you consider some of your weaknesses?

What would you like to accomplish in your therapy?

Client Signature Date

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