Shobana Nuland, LMHC
134 NW 183rd St
Shoreline, WA 98177
(206) 546-5390
www.shobananuland.com
Washington State License #LH00005145

Intake Form

Please note: Information that you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Date of Birth: _____/_____/_____ Gender: Male_____ Female_____

Marital Status:

Never Married_____ Domestic Partnership_____ Married_____ Separated_____
Divorced_____ Widowed_____

List any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip Code)

Home Phone: _____ May I leave a message? Yes_____ No_____

Cell Phone: _____ May I leave a message? Yes_____ No_____

Email: _____ May I email you? Yes_____ No_____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by: _____

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

No_____ Yes_____

Previous 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/Mental Health Information

1. How would you rate your current physical health? (Please circle)

   Poor Unsatisfactory Satisfactory Good Very good

   Please describe any current health problems you are experiencing:

_____

2. How would you rate your current sleep habits? (Please circle)

   Poor Unsatisfactory Satisfactory Good Very good

   Please describe any current specific sleep problems you are experiencing:

_____

3. Generally how many times a week do you exercise? _____

   What types of exercise do you participate in? _____

4. Please describe any difficulties you have with your appetite or eating habits:

_____

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 in recreational drug use? (Please circle)

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, with 10 being the best, 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:

Issue	**Please Circle**	**List Family Member**
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

Additional Information:

1. Are you currently employed? No_____ Yes_____

   If yes, what is your employment situation?

_____

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

_____

_____

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 weaknesses?

5. What would you like to accomplish from your time in therapy?