

Intake Form
David 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: _____

Position: _____

4) Marital Status _____ Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____

Children: 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? _____ How often? _____

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 Davida Cohen? _____

11. What do you Wish to Achieve with Therapy? _____

Check Any of the Following That May Apply to You:

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

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