Intake Form

Beth Estergomy LCSW Holistic Psychotherapist

Biopsychosocial Assessment

Name: DOB: Email: Date:

Address:

Home Phone: Cell: Work:

Emergency Contact Name: Phone:

Reason for visit:

Treatment History

Have you been in therapy before? Y/N If yes please describe:

Please list any inpatient psychiatric hospitalizations:

Past diagnosis/symptoms/Current psychiatric medications:

Have you ever thought about or attempted suicide? Explain:

Personal History

Where were you born? Briefly describe your childhood:

Have you ever been physically or sexually abused, please explain:

Siblings, #of brothers # of sisters How is your relationship?

Religion: Education: Marriage/Relationship status:

Describe social relationships:

Do you drink alcohol? Y/N If yes how often? Have you ever blacked out? Y/N

Do you think you have a problem with alcohol?

Have you used drugs in the past or currently use drugs? Y/N If yes what kind and how often?

Work history:

What do you do for enjoyment?