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?