Joshua Magallanes, MA LMHC NCC
Joshua Magallanes, LLC
2331 E. Madison Street
Seattle WA 98112
206-707-9710
www.joshuatherapy.com

INTAKE FORM

Please provide the following information for my records. Leave blank any questions you would rather not answer. This information is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Name: _____

Birth date: _____ Age: _____ Gender: _____

Preferred Pronouns: _____ Sexual Orientation_____

Email: _____

Marital Status: _____Number of Children: _____

Address: _____

Home Phone: _____May I leave a message? _____

Cell/Other Phone: _____May I leave a message? _____

Referred by: _____

Please provide names and phone numbers of two emergency contacts (day and evening phone, and relationship to contact):

_____

_____

HEALTH AND SOCIAL INFORMATION

1. Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? If yes, please provide name of other provider:

_____

2. Are you currently taking prescribed psychotropic medication (antidepressant or other)? If yes, please list:

_____

If you are not currently taking such medication, have you in the past? If yes, please list:

_____

3. How is your physical health at present? (Please circle)
Poor Unsatisfactory Satisfactory Good Very Good
Please list any persistent physical symptoms or health concerns, or any disabilities:
_____
_____
4. Are you having any problems with sleep? If yes, please describe:
_____

5. Are you having any problems with appetite or eating habits? If yes, please describe:
_____

6. Have you gained or lost a significant amount of weight in the past two months?
_____

7. Do you regularly use alcohol? _____In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

8. How often do you engage in recreational drug use?
_____

9. Have you had suicidal thoughts recently?
_____
Have you had suicidal thoughts in the past?
_____

10. In the last year, have you experienced any significant life changes or stressors?
_____
_____
_____
Please circle any of the following you have experienced or are experiencing:
Extreme depressed mood
Wild mood swings
Rapid speech
Extreme anxiety
Panic attacks
Phobias
Sleep disturbances
Hallucinations
Unexplained losses of time
Unexplained memory lapses
Alcohol/substance abuse
Frequent body complaints
Eating disorder
Body image problems
Repetitive thoughts (obsessions)
Repetitive behaviors
Homicidal thoughts
Suicide attempt

OCCUPATIONAL INFORMATION:

Are you currently employed? _____If yes, who is your employer and what is your position?
_____
Are you satisfied with your current occupational situation?
_____
Please list any work-related stressors, if any:
_____

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your immediate or extended family experienced difficulties with any of the following? Please circle any that apply and list family member.
Depression
Bipolar Disorder
Anxiety Disorder
Panic Attacks
Schizophrenia
Alcohol/Substance Abuse
Eating Disorders
Learning Disabilities
Trauma History
Suicide Attempts
Is there anything else you would like me to know before we begin talking?
_____
_____
_____