Name:_____

JANE MARKE, MD

37 West 20 Street, Suite 310, New York, NY 10011
Fax/ Ph: 212.228.2332

Intake Form

Please fill out this form and bring it to your first session/email it or fax it back to us.

Photo

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

Birth Date: _____ Age: _____ Gender: ○ Male ○ Female ○ Other

Phone: _____ Email: _____

Address: _____
(Number/Street) (City) (State) (Zip)

Pharmacy: _____ _____
(Name) (Phone number)

Referred by (if any): _____

Reset Form Save Form

Name:_____

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Emergency Contact:

_____
(Last) (First) (Relationship)

Phone: _____ Email: _____

Person Responsible for Payment:

_____
(Last) (First)

Phone: _____ Email: _____

Email where invoices should be sent: _____

Marital Status:

○ Never Married	○ Domestic Partnership	◒ Married
○ Separated	○ Divorced	○ Widowed

Please list any children/ages: _____

Address: _____

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? ○ Yes ○ No
Cell/Other: ( ) May we leave a message? ○ Yes ○ No
E-mail: _____ May we email you? ○ Yes ○ No

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ○ No ◒ Yes previous therapist/practitioner:

_____

Are you currently taking any prescription medication? ○ Yes ○ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication? ○ Yes ○ No

Please list and provide dates: _____

_____

_____

Are you currently employed? ○ No ○ Yes

If yes, what is your current employment situation?

_____

_____

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

_____

_____

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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. What is the major problem you would like me to help you with?
   _____
   _____
   _____
   _____

2. How would you rate your current physical health? (please circle)
   ○ Poor ○ Unsatisfactory ○ Satisfactory ○ Good ○ Very good

   Please list any specific health problems you are currently experiencing:
   _____

3. How would you rate your current sleeping habits? (please circle)
   ○ Poor ○ Unsatisfactory ○ Satisfactory ○ Good ○ Very good

   Please list any specific sleep problems you are currently experiencing:
   _____

4. How many times per week do you generally exercise? _____
   What types of exercise to you participate in? _____

5. Please list any difficulties you experience with your appetite or eating patterns:
   _____

6. Are you currently experiencing overwhelming sadness, grief, or depression?
   ○ No ○ Yes

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7. Are you currently experiencing anxiety, panic attacks, or have any phobias?
   ○ No ○ Yes

8. Are you currently experiencing any chronic pain? ○ No ○ Yes
   If yes, please describe:
   _____

9. Do you drink alcohol more than once a week? ○ No ○ Yes

10. How often do you engage recreational drug use?
    ○ Daily ○ Weekly ○ Monthly ○ Infrequently ○ Never

11. Are you currently in a romantic relationship? ○ No ○ Yes
    If yes, for how long? _____
    On a scale of 1-10, how would you rate your relationship? _____

12. What significant life changes or stressful events have you experienced recently:
    _____
    _____
    _____

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FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Select	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	_____

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Do you consider yourself to be spiritual or religious? ○ No ◒ Yes

If yes, describe your faith or belief:

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

Print Form Reset Form Save Form