Dr. Toni Warner-McIntyre, LCSW
607 Easton Rd., Suite B-2
Willow Grove, PA 19090
(215) 437-3414
drtoniwarner@gmail.com
www.authenticallymepsychotherapy.com

INTAKE FORM
AUTHENTICALLY ME PSYCHOTHERAPY, LLC

(Please provide as much detail as possible, we will review this together during our first session)

Name: _____ **Gender:** _____

Intake Date: _____ **Age:** _____ **Date of Birth:** _____

E-mail: _____ **Phone:** _____

Mailing Address (where you live. Please note that you must live in PA in order for me to provide you clinical services):

_____

_____

Initial next to "Y" for Yes and "N" for No. It's okay for Dr. Toni to:

Call cell/phone? Y_____ N_____ Leave A Voicemail? Y_____ N_____

E-mail? Y_____ N_____ Okay to Text? Y_____ N_____

Current Relationship Status: _____ **Partner(s):** _____

Sexual Orientation/ Who are you attracted to?_____

What issue(s) brings you in today?

_____

_____

_____

In the past 6 months, have you experienced any of the following (check off all applicable spaces):

_____ Anxiety	_____Fatigue	_____Loss of interest
_____ Crying spells	_____Guilt	_____Panic attacks
_____Depression	_____Hallucinations	_____Issues sleeping
_____Hopelessness	_____Impulsivity	_____Other. Describe:
_____Excessive Energy	_____Irritability	

Share more information about above checked off areas here: _____

_____

_____

Are there certain persons, places or things you have been avoiding that are impacting your daily functioning? If yes, please explain _____
_____

Is there currently, or has there ever been, an important person in your life that regularly puts you down? If yes, please explain_____
_____

Previous therapy/treatment (please describe what type and if it was/wasn't helpful):
_____
_____

What has helped to manage the current issues?
_____
_____

What makes the current issues worse?
_____
_____

What are your strengths and interests? _____
_____

What makes you feel happy? _____
_____

Religious/Spiritual Affiliation: _____
(share if your religion/spiritual beliefs are different from your family's)

Any head, neck or jaw pain or head/neck injuries (*concussions, ear pain, TMJ, etc***.):**
_____
_____

Medical conditions (share if you're being treated for any):
_____
_____

Current Medications or Supplements (share if you are taking them regularly):
_____
_____

Medications in past: _____
*(reason for discontinuing):*_____

Any previous mental health diagnosis: _____
_____

Would you like me to be able to connect with other professionals, to more holistically support you? Communication would only be done with your knowledge and consent. Please identify which other professionals you'd like me to communicate with:

PCP: _____ ***#:*** _____

OBGYN: _____ ***#:*** _____

Dentist: _____ ***#:*** _____

School: _____ ***#:*** _____

Court/JPO: _____ ***#:*** _____

Lawyer: _____ ***#:*** _____

Therapist: _____ ***#:*** _____

Psychiatrist: _____ ***#:*** _____

Specialist: _____ ***#:*** _____

Specialist: _____ ***#:*** _____

Other: _____ ***#:*** _____

Eating difficulties and/or eating habits: _____
_____

How often do you drink water? _____ **Caffeine?**_____ **Alcohol?** _____

Describe your physical movement routine? (i.e. sit at desk all day, work out weekly, daily walks)_____
_____

Describe your overall health: _____

Sleeping difficulties and/or sleeping habits: _____
_____

Do you often crave or dislike physical touch or body pressure? _____
_____

Are there certain sounds, smells or textures that bother you or comfort you? _____
_____

Sexuality-related challenges (i.e. heightened arousal, inability to engage sexually, fear of sexual engagement):
_____
_____

What is your relationship like with your parents?

_____
_____
_____

Describe what your relationships have been like with your current and/or past partners? _____
_____
_____
_____

Any family issues you want me to know about up front?

_____
_____
_____

Have you experienced neglect, abuse or trauma?

_____
_____
_____
_____

Are you engaging in any risk taking behaviors (i.e. stealing, putting self in dangerous situations on purpose):

_____
_____

Do you sometimes or often *(circle one)* **lose chunks of time** *(describe):* _____
_____

Do you sometimes or often *(circle one)* **dissociate or feel separate from body** (describe): _____
_____

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 (e.g. father, grandmother, uncle, etc.)
Please Circle yes or no.

		List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____
Bipolar Disorder	yes / no	_____
Other		_____

History of suicide attempt or ideation: _____
_____

Currently suicidal: _____
_____

******If you are actively struggling with wanting to kill yourself, please stop completing this form and immediately reach out to 9-1-1 or a trusted adult that can take you to a crisis center to receive the necessary acute care to become stabilized. Authentically Me Psychotherapy, LLC is not a crisis center and cannot provide acute care.******

History of self-harm: _____
_____

Currently self-harming: _____
_____

If you answered yes to any suicide or self-harm questions, are you willing to commit to a goal of safety with and for yourself, during our time together, while we work on strengthening your ability to create and maintain relationships with yourself and others that feel safe, trusting and comforting?

YES or NO *(circle one)*

What are your primary goals in coming to therapy at this time? In other words, how would you know that treatment has been helpful for you? _____
_____
_____
_____

How did you discover Authentically Me Psychotherapy, LLC: _____

Anything else you want me to know before we start working together?
_____
_____
_____
_____
_____
_____
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_____

YOU HAVE TAKEN A COURAGEOUS STEP BY CHOOSING THERAPY.
YOU ARE ALREADY ON YOUR WAY TO PROGRESS!