



**NINA HOLMES MA, MFT  
THERAPY INTAKE FORM**

*Please provide the following information for my records. Information you provide here is held to the same standards of confidentiality as our therapy. Thank you!*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Insured's name if not self: \_\_\_\_\_ Insured's date of birth: \_\_\_\_\_

Insured's phone number: \_\_\_\_\_

Insured's address if different from yours: \_\_\_\_\_

Your Address \_\_\_\_\_

(Please include your zip code) \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Ok to send appointment reminders to your home phone? \_\_\_\_\_ to your cell phone? \_\_\_\_\_

E-mail address: \_\_\_\_\_ OK to email reminders? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Your Mental Health**

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

Yes No If yes, please briefly explain for what and medication if prescribed:

\_\_\_\_\_  
\_\_\_\_\_

Have you previously been seen a therapist or been prescribed psychotropic medication?

Yes No If yes, please explain for what and medication if prescribed:

\_\_\_\_\_  
\_\_\_\_\_

Below please check the applicable symptoms:

	Yes a lot	Somewhat	Rarely	No	History of
Depressed mood					
Wild mood swings					
Rapid Speech					
Anxiety					
Panic attacks					
Phobia of:					
Sleep Disturbances					



	Yes a lot	Somewhat	Rarely	No	History of
Hallucinations					
Unexplained losses of time					
Unexplained memory lapses					
Alcohol/Substance abuse					
Frequent body complaints					
Eating disorder					
Body image problems					
Repetitive thoughts					
Repetitive behaviors					
Homicidal thoughts					
Suicidal thoughts					

Please state how you came to decide to come for counseling/therapy: \_\_\_\_\_

---

---

---

---

---

How long has this been a problem for you? \_\_\_\_\_

---

---

---

---

What are your goals for therapy? \_\_\_\_\_

---

---

---

---

Add anything else in the space below that you think would be helpful for me, as your therapist, to know.

---

---

---