Courtney Dowdell Therapy

240 Madison Avenue, #10D
New York, New York 10016

Intake Form

Please provide the following information for your records. Leave blank any questions you would rather not answer in print. Information you answer here is held to the same standards of confidentiality as your counseling sessions.

Background Information

Name: (Last) _____(First)_____
Name: (Last) _____(First)_____
(Parent or guardian if client is a minor)

Address:

_____
(Street)

_____ _____ _____
(City) (State) (Zip code)

Date of birth: _____/_____/_____ Age: _____ Preferred gender pronoun: _____

Living Situation: _____

(circle one) Single Partnered Married Separated Divorced Widowed

Work/School: _____

Phone number: _____ Is it okay to leave a message here? ___

Email: _____

Referred by: _____

Emergency Contact : _____
(name & phone number)

Insurance Type & Member ID Number: _____
_____

Treatment History

Please list any prior therapy history and/or treatment including residential stays, intensive outpatient programs and previous individual providers. Please include age, facility name & length of stay. What worked and did not work for you?

Medical History

Please list any medical complications, surgeries/procedures, or physical symptoms:

Current Prescription Medications

Please list prescription dose, how long you have been prescribed the medication, as well as any side effects experienced:

Family History

Family psychiatric history:

Family composition:

Who is in your family of origin and/or family of choice?

Below are a series of short statements/questions, please check all boxes that are currently true for you:

Anxiety:

▢ Fear or anxiety about social situations (meeting new people, being observed eating in front of others,etc)
▢ Avoid social situations, or endure them with intense fear or anxiety
▢ Fear or anxiety is out of proportion to the actual threat posed by the situation
▢ Recurrent panic attacks (abrupt surge of intense fear/intense discomfort)
▢ Fear or anxiety about using public transportation, being in open spaces, being in enclosed spaces or being outside of your home
▢ Excessive anxiety and worry that occurs more days than not about a number or activities (work, school)
▢ Find it difficult to control the worry
▢ Feeling restless, or on edge
▢ Easily fatigued
▢ Difficulty concentrating, mind goes blank
▢ Irritability
▢ Muscle tension
▢ Sleep disturbance (difficulty falling asleep, staying asleep, unsatisfying sleep)

If yes to any of these, how long have you been feeling this way? 6+ months? Or less than 6 months?

_____

Have you ever been prescribed medication for anxiety? If yes, please list psychiatric medication, dosage, and frequency.

_____

Depression

▢ Depressed mood most of the day, nearly every day for the past 2 weeks
▢ Loss or decline of interest in activities and hobbies you used to enjoy for the past 2 weeks
▢ Any weight loss or weight gain over the past 2 weeks
▢ Insomnia or hypersomnia nearly every day for the past 2 weeks
▢ Fatigue or loss of energy nearly every day
▢ Feelings of worthlessness or excessive guilt nearly every day
▢ Indecisiveness, or inability to concentrate nearly every day
▢ Have these feelings contributed to any impairment in your life (social, work, home life)
▢ Have you ever been prescribed any medications for depression
▢ Thoughts of death, thoughts of suicide

If yes to any of these, how long have you been feeling this way? 6+ months? Or less than 6 months?

_____

Have you ever been prescribed medication for depression? If yes, please list psychiatric medication, dosage, and frequency.

_____

Suicide and Self-Harm

▢ Any thoughts about a plan to commit suicide (selected a location, wrote a note, obtained pills)
▢ Do you intend to act on this plan
▢ Do you have any past history of suicidal thoughts or a plan
▢ Have you ever self-harmed in any way
▢ If yes, what did you use? When was the most recent time? _____

Substance Use

▢ How many alcoholic drinks do you have per day/week? _____
▢ Ever felt like you were drinking too much and tried to cut down on your alcohol use but could not
▢ Any cravings for alcohol
▢ Does your drinking interfere with any area of your life (school, work, home)
▢ Ever attended AA, or was recommended to attend AA, or any treatment for alcohol use
▢ Using any drugs (prescription drugs, OTC drugs, cannabis)
▢ Every felt like you were using the substance too much or tried to cut down on your substance use but could not
▢ Any cravings for those substances
▢ Does your substances use interfere with any area of your life (school, work, home)

Trauma Experiences and Symptoms

Ever experienced any of the following traumatic events:
▢ Death or temporary loss of a loved one
▢ Physical abuse
▢ Sexual abuse
▢ Rape
▢ Verbal abuse
▢ Emotional abuse
▢ Accidents
▢ Parents fighting
▢ Chronic illness
▢ Burns or serious injury
▢ Alcoholism/drug abuse
▢ Divorce of parents

If any of the above boxes checked, please continue:
▢ Ever experienced any recurrent, involuntary, and intrusive memories of the event(s)
▢ Recurrent distressing dreams of the event, or the content is related to the traumatic event
▢ Flashbacks

▢ Feeling psychological distress when thinking about or seeing something that resembles the traumatic event
▢ Feeling physiological distress when thinking about or seeing something that resembles the traumatic event
▢ Avoid distressing reminders of the traumatic event (people, places, activities)
▢ Inability to remember important aspects of the traumatic event(s)

Goals for therapy:

What would you like to achieve from therapy?

Strengths:

List (at least) three of your strengths.

Anything else?

Is there anything else you would like me to know or that may be helpful for me to know you?