

The Center for Treatment of Anxiety and Mood Disorders  
Andrew Rosen Ph.D., FAACP

**Patient Intake Form**

Please provide the following information and answer the questions below. Note: The information you provide here is protected as confidential information.

Please fill out this form completely and bring it to your first session.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Name of parent/guardian (if under 18 years):

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:

Never Married  Domestic Partnership  Married  Separated

Divorced  Widowed

Please list any children and age: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: (\_\_\_\_) \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): \_\_\_\_\_

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?  Yes  No

If Yes, previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication?  Yes  No

If Yes, please list: \_\_\_\_\_

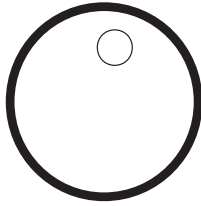
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4600 Linton Blvd., Suite 310 | Delray Beach, FL 33445

[www.drandrewrosen.com](http://www.drandrewrosen.com)

Office: (561) 496-1094 | Fax: (561) 498-7698



# The Center for Treatment of Anxiety Disorders

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Have you ever been prescribed psychiatric medication?  Yes  No

Please list and provide dates: \_\_\_\_\_  
\_\_\_\_\_

## GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (please check one)

Poor  Unsatisfactory  Satisfactory  Good  Very good

Please list any specific health problems you are currently experiencing:

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

2. How would you rate your current sleeping habits? ((please check one)

Poor  Unsatisfactory  Satisfactory  Good  Very good

Please list any specific sleep problems you are currently experiencing:

\_\_\_\_\_

3. How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise to you participate in: \_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating patterns.

\_\_\_\_\_

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

If yes, for approximately how long? \_\_\_\_\_

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

If yes, when did you begin experiencing this? \_\_\_\_\_

7. Are you currently experiencing any chronic pain?  Yes  No

If yes, please describe? \_\_\_\_\_

8. How many drinks of alcohol do you have in a week? \_\_\_\_\_

9. Do you use recreational drugs?  Yes  No

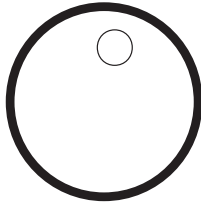
If yes, which ones: \_\_\_\_\_

How often?  Daily  Weekly  Monthly  Infrequently

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10. Are you currently in a romantic relationship?  Yes  No

If yes, for how long? \_\_\_\_\_

On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 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.).

#### Family History:

#### Check one:

#### Family Member Relationship:

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

\_\_\_\_\_

### ADDITIONAL INFORMATION:

1. Are you currently employed?  Yes  No

If yes, what is your current employment situation:

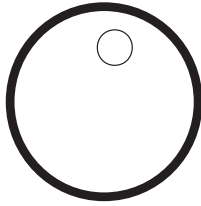
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Do you enjoy your work? Is there anything stressful about your current work?

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2. Do you consider yourself to be spiritual or religious?  Yes  No

If yes, describe your faith or belief:

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3. What do you consider to be some of your strengths?

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4. What do you consider to be some of your weaknesses?

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5. What would you like to accomplish out of your time in therapy?

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