Maine & Weinstein Specialty Group, LLC

RAPID RESOLUTION THERAPY INTAKE FORM

Name: _____ Date: _____

What brings you in today? _____

_____

What would you like to accomplish in your session today? _____

_____

Please list your current medications _____

_____

Do you drink alcohol? YES ☐ NO ☐ How much? _____ How often? _____

Do you use other substances? YES ☐ NO ☐ How much? _____ How often? _____

Do you drink tea/coffee/caffeinated drinks YES ☐ NO ☐ How much? _____ How often? _____

Have you ever or are you now being treated for any type of chemical dependency? YES ☐ NO ☐

If yes, when? _____ Where? _____

Have you ever received psychotherapy/counseling YES ☐ NO ☐

If yes, therapist's name: _____

Reason for treatment: _____

_____

Have you ever been hospitalized for any mental health reasons? YES ☐ NO ☐

If yes, please explain: _____

Do you have a history of Abuse? Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ N/A ☐

If yes, please explain: _____

_____

Do you have or have you ever had thoughts of harming yourself? YES ☐ NO ☐

If yes, please explain: _____

_____

Have you every harmed yourself? YES ☐ NO ☐

If yes, please explain: _____

_____

Do you currently have any thoughts of committing suicide? YES ☐ NO ☐

If yes, please explain: _____

_____

Have you ever attempted to commit suicide? YES ☐ NO ☐

If yes, please explain: _____

_____

Do you have or have you had thoughts of harming others? YES ☐ NO ☐

If yes, please explain: _____

_____

Are you currently at risk of being harmed by anyone? YES ☐ NO ☐

If yes, please explain: _____

_____

Do you hear or have you heard voices that other people cannot hear? YES ☐ NO ☐

If yes, please explain: _____

_____

Do you have or have you ever seen images that others cannot see? YES ☐ NO ☐

If yes, please explain: _____

_____

Are you involved with any legal actions? YES ☐ NO ☐

If yes, please explain: _____

_____

Please check all that apply:

Sleep Problems:

Trouble getting to sleep ☐ Waking up at night ☐ Waking up too early ☐

Nightmares or vivid dreams ☐ Oversleeping ☐ Excessive snoring ☐

Eating Problems:

Overeating ☐ Loss of appetite ☐ Bingeing or purging ☐

Weight change in the past month:

None ☐ Gain ☐ Loss ☐ No. of lbs: _____

Have you recently had any significant changes in your health or medical status? YES ☐ NO ☐

If yes, are you currently receiving treatment for the condition? _____

_____

What are some of your strengths? _____

_____