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Intake Form

Please fill out the following form and bring to our first session. Information you provide here is held under the same standards of confidentiality as our therapy.

Date _____

Name _____
(First) (Middle Initial) (Last)

If you are a minor, name of parent/guardian _____

Date of Birth _____ **Age** _____

Address _____
(Street and Number)

(City) (State) (Zip Code)

Phone: (day) _____ **(evening)** _____

May I leave a message at the above listed phone numbers: _____

E-mail: _____

May I e-mail you? _____

*** please note that e-mail is not a confidential medium. I prefer to limit e-mailing for scheduling purposes.**

Referred by (if any) _____

Please check the appropriate line:

___ **never married** ___ **Divorced**

___ **separated** ___ **Widowed**

___ **domestic partnership/married** If yes, please provide the first name of your partner and the length of time together _____

___ **in an intimate relationship** If yes, please provide the first name and the length of time together _____

If you are currently employed or in school, please list the name of your employer/school and occupation _____

Person to Contact in an Emergency _____

Phone _____ **Address** _____

Relation to you _____

Please list the major problems that you would like help with in therapy:

Briefly describe what motivated you to seek therapy at this time (rather than earlier or later):

Family Composition

Please list all members in your family of origin including yourself:

Name **Relation to You** **Age** **Occupation**

Do you have children? If yes, please list the gender and ages:

Do you have any serious medical conditions? If yes, please describe.

List any medications you are currently taking:

Have you ever been prescribed psychiatric medication? Please list and provide dates:

Have you experienced any recent life changes or losses?

Have you felt any of the following? Please check:

Trembling, shaking _____ Nausea/digestion distress _____
Feelings of choking _____ Dizzy, lightheaded or faint _____
Shortness of breath _____ Feelings of unreality or detached from oneself _____

Number of family members with: Alcohol/drug problems ____ Psychiatric Problems
(depression, anxiety, psychosis) _____

Do you consider yourself to be spiritual or religious? If yes, describe your faith or belief

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? If yes, list name of provider, duration, and reason for termination: _____

Please list your goals for therapy? _____
