Leyla Mahbod Kenny, PhD, LICSW
1350 Connecticut Avenue, NW Suite 603
Washington, D.C. 20036
(202) 251-2884

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?_____

_____

_____

_____