UIRC
Utah Infertility
Resource Center

1565 East 3300 South
Salt Lake City, UT 84106
385-313-0990
utahinfertilityresourcecenter.org

Intake Form

Please provide the following information. This form is protected as confidential information.

GENERAL INFORMAION

Full Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Phone Number: _____ Email: _____

Address: _____

City, State, Zip: _____

Emergency Contact: _____ Phone Number: _____

Referral Info: _____

HEALTH & MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services? No Yes

   If yes, previous therapist/practitioner: _____

2. Are you currently taking any prescription medications: No Yes

   If yes, please list:

   Medication: _____ Duration: _____

   Medication: _____ Duration: _____

   Medication: _____ Duration: _____

3. Have you ever been prescribed psychiatric medication *in the past?* No Yes

   If yes, please list:

   Medication: _____ Duration: _____

   Medication: _____ Duration: _____

   Medication: _____ Duration: _____

4. How would you rate your current physical health?

Very Good Good Satisfactory Unsatisfactory Poor

5. Please list any health problems you are currently experiencing:

_____

_____

_____

6. How would you rate your sleeping habits?

Very Good Good Satisfactory Unsatisfactory Poor

7. Please list any sleeping problems you are currently experiencing:

_____

_____

_____

8. Please list any difficulties with appetite or eating patterns:

_____

_____

_____

9. Have drugs or alcohol ever impacted your ability to function:

_____

_____

10. Have you ever experienced physical abuse/neglect? Yes No

11. Have you ever experienced sexual abuse? Yes No

12. Have you ever experienced other traumatic experiences? Yes No

INFERTILITY INFORMATION

13. Please outline your infertility treatment to this point (if any). Include treatment type and approximate dates. _____

_____

_____

_____

14. Have you ever experienced a pregnancy loss? No Yes

If so, when: _____

15. Please check which parts of your life infertility has impacted.

_____ Relationship with Partner

_____ Career or Hobbies

_____ Spirituality or Religion

_____ Finances

_____ Other Family Relationships

_____ Identity or Role

_____ Sex

_____ Other: _____

FAMILY MENTAL HEALTH HISTORY

In this section, please 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.

			Family Member
Alcohol/Substance Abuse	No	Yes	_____
Anxiety/Panic/OCD	No	Yes	_____
Bipolar Disorder	No	Yes	_____
Depression	No	Yes	_____
Domestic Violence	No	Yes	_____
Eating Disorders	No	Yes	_____
Schizophrenia	No	Yes	_____
Suicide Attempts	No	Yes	_____

ADDITIONAL INFORMATION

16. Are you currently employed? No Yes

If yes, please describe your position:_____

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

_____

_____

_____

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

_____

_____

_____

18. What would you like to accomplish during your time in therapy?

_____

_____

_____

20. How motivated do you feel about the changes you would like to make?

Low 1 2 3 4 5 6 7 8 9 10 High