Intake Form

Were You Referred: Yes __ No__ Name of Referral:_____
Did you find me on the internet? Yes ___ No___
If so, please provide the name of the site (if you remember) _____
Thank you.

Name: (Please Print)	**Date:**
Address: **City: Zip:**	**Date of Birth:** **Gender: Female____ Male____**
Martial Status: _____ **How Long Married or in Relationship:_____** **# of Children:_____** **Names/Ages: _____** **_____**	**Home Phone:** **Cell Phone:**
Emergency Contact: **Emergency Phone:** **Relationship to Client:**	**Occupation:** **Work Phone:**
Email Address:	

Present Living Arrangement/Background Information:

With whom are you living?_____
Name: _____ Relationship_____

Presenting Problem/Concern:

_____
_____
_____

Therapy Expectations

If therapy is successful, what will change:

_____
_____

Other Complaints and Symptoms (eating, sleeping, drugs and alcohol use):

_____

Suicide and Violence Assessment

Current Risk for Suicide: ( ) None ( ) Low ( ) Medium ( ) High

Suicidal History (date/method of attempts):_____
_____

Current Risk for Violence/Dangerousness: ( ) None ( ) Low ( ) Medium ( ) High

Medications

1) Name:_____Reason:_____
2) Name:_____Reason:_____
3) Name:_____Reason:_____
4) Name:_____Reason:_____

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations, current medication)

_____

_____

MEDICAL DOCTOR(S): _____ PHONE(S): _____

LAST EXAM _____

Head Injuries/Chronic Diseases

_____

_____

Past/Present Counseling/Psychotherapy/Mental Hospital

Therapist: _____ Dates: _____to _____Phone: _____

Initial reason: _____Outcome: _____

Therapist: _____Dates: _____ to _____ Phone: _____

Initial reason: _____ Outcome: _____

Family Background:

Parents still living? *Father* ( ) Yes ( ) No *Mother:* ( ) Yes ( ) No

Parents: ( ) Married ( ) Separated ( ) Divorced ( ) Never married

Siblings (names/ages): _____

_____

History of physical/emotional/verbal abuse in your family?_____

_____

_____

Psychiatric conditions in your family?_____

_____

History of Alcoholism/Drug Addiction in your family? _____

_____

Additional comments:_____

_____

Social/Educational Background

Religious upbringing:_____
Current Religious Affiliation:_____

Education:_____

Important people in your life/support system:_____
_____
_____
_____

Therapy Expectations

Do you have any particular goals that you would like to see met in therapy? Please explain: _____
_____
_____