INTAKE FORM

Personal Information:

Name:_____ Birth date_____

Address:_____

Cell phone:_____ Home phone:_____ Best time to contact_____

Age:_____ Sex:_____ Referred by: _____

Employer: _____ Position:_____ Years_____

Marital Status (circle one): Married # of years_____
Divorced # of years_____
Single
Widowed
Cohabitating # of years_____

Spouse/Partner Info

Spouse:_____ Age:_____ Birth date:_____

Occupation: _____ Years employed:_____

Home Phone:_____ Cell phone:_____ Best time to contact_____

Marriage Info

Date of marriage_____ Length of dating_____

Attending therapy with:_____

Any previous marriages: _____Yes _____ No If yes, #_____ Length of marriage(s) _____

How did previous marriages
end?_____
_____
_____

Other Members of Household

Name:_____ Male or Female

Age:_____ Relationship:_____

Name:_____ Male or Female

Age:_____ Relationship:_____

Name:_____ Male or Female

Age:_____ Relationship: _____

Name:_____ Male or Female

Age:_____ Relationship:_____

Children not currently living with you

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

In the case of an emergency contact

Name:_____ Contact #_____

Relationship:_____

Therapy Information

Previous therapy? ___Yes _____No Currently in therapy elsewhere: _____Yes _____No

If yes describe when and where:_____

Have you been diagnosed with any chronic condition:_____

Previous diagnosis (both medication and psychological):_____

Currently on medications: _____Yes _____No If yes, which ones_____

_____

Previous inpatient psychiatric and/or drug-alcohol rehab
hospitalizations?_____

_____

Reasons for attending therapy (sources of stress that brought you to therapy):

1._____

2._____

3._____

Goals for therapy

1._____

2._____

3._____

Current Functioning: Please circle on the following scale to indicate how well you are coping at the present time. 100% means that you are coping the best that you can considering your situation:

0%-----10%------20%-------30%------40%-----50%------60%------70%-------80%------90%------100%

Social Network:

Religious Affiliation if any: _____Church Affiliation_____

Attend any services _____Yes _____No How often?_____

What best describes current relationships you have with friends (check one)?

____I have several strong friendships ____I have a few close friends ____ I have no friendships

What describes current relationships with family (check one)?

___I am close and feel support with family

___I am close to some family but others are a great source of frustration or stress

___I have no family close by

___I have family close by but they are a source of great tension an danger.

Home

I have been violent in the home Never Just a little Pretty much Very much N/A
Please describe_____

My spouse has been violent Never Just a little Pretty much Very much N/A
Please describe_____

My children have witnessed violence Never Just a little Pretty much Very much N/A
Please describe_____
Other comments:
_____
_____
_____

Problem Checklist (circle all that apply):

Abused as child	Fear	Post-abortion trauma
Addictions	Financial Troubles	Rebellious
Anger/Bitterness	Gambling	Same-sex preference
Anxiety or Panic Attack	Gluttony	Sexual troubles
Apathy	Grief/Loss	Sleep troubles
Blended family issues	Guilt/Shame	Spousal conflicts
Change in lifestyle	Health Problems	Suicidal Thoughts or actions
Children	Infertility	Unresolved conflicts
Control Issues	In law/Parent problems	Violence in the home
Communication Issues	Life transition problems	Low self-esteem
Depression	Memory Problems	Work problems
Eating Disorders	Mood swings	A Vice
Employment Issues	Parent-Child Conflict	Divorce Issues
Spiritual problems	Sexual abuse (child or adult)	Marital trouble

Do you currently consume alcohol? ___Yes ___No If yes answer questions below:
Date of last use_____ Amount_____ # of years used_____
Frequency?___Daily ____2-3x week ___Weekly ___Monthly ___Less than once a month
Do you currently use any substances (drugs or prescription drugs)? ____Yes ____No
If yes answer questions below:
Date of last use _____ Amount_____ # of years used _____
Frequency?___Daily ____2-3x week ___Weekly ___Monthly ___Less than once a month
Describe any problems that affect your daily functioning (job, relationship, sleep, ability to care for yourself or your children).
_____
_____

_____
_____

Family History

Does your family have any history of psychiatric, mental illness, suicide, depression, substance abuse, eating disorder (anorexia, bulimia, binge eating), or other additions (please describe is yes)?

_____
_____
_____
_____

Major family health problems (please list)_____
_____
_____
_____

How many sessions do you think you will need to get back on track?

___Don't know ___1-3 sessions ___4-6 sessions 7-9 sessions ___10-12 sessions ___Other

Additional information:

_____
_____
_____