Intake Form

Name: _____ Address: _____

City: _____ State: _____ Zip code:_____

Phone # _____ Cell phone: _____ Email: _____

Last four of SS# _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Employer: _____ Occupation: _____

Please check any if reasons listed below which resulted in you coming to therapy today?

☐ Depression ☐ Anxiety ☐ Alcohol ☐ Drugs ☐ Marital Issues ☐ Family Counseling

☐ Relationship Enhancement ☐ Improvement Sexual Relations ☐ Abuse Sexual/Physical ☐ Individual Counseling

☐ Pre- Marital Counseling ☐ Communications Difficulties ☐ Difficulty with Death ☐ Divorce Counseling

☐ Other:_____

History:

☐ Anxiety ☐ Depression ☐ Anger ☐ Addiction (Drugs/Alcohol)

☐ Withdrawn ☐ Constricted ☐ Hostile ☐ Other Mental Illness

What are your current symptoms?

_____

_____

How long have you experienced your current symptoms?

_____

_____

What made you come to treatment now?

_____

_____

What do you expect from Treatment?

_____

_____

Medical Problems?

_____

_____

Any Medications ?

_____

_____

_____

Primary Physician: _____

Substance Abuse: ☐ Yes ☐ No

Have you ever been in treatment facility for substance abuse: ☐ Yes ☐ No

If yes above please explain:

_____

_____

_____

Mothers Name: _____ Age: _____ ☐ Deceased ☐ Living

If deceased cause of Death? _____

Substance Abuse? ☐ Yes ☐ No if yes please explain:

_____

_____

Quality of Relationship:

☐ Great ☐ Good ☐ Fair ☐ Poor

Fathers Name: _____ Age: _____ ☐ Deceased ☐ Living

If deceased cause of Death? _____

Substance Abuse? ☐ Yes ☐ No if yes please explain:

_____

_____

Quality of Relationship:

☐ Great ☐ Good ☐ Fair ☐ Poor

Relationship Status:

☐ Single ☐ Cohabitating (Living Together) ☐ Divorced ☐ Separated ☐ Widowed

☐ Significant Other ☐ Remarried (After Divorced) ☐ Remarried (After Death) ☐ Married (First)

Significant others name:

_____

If deceased cause of Death? _____

Substance Abuse? Yes ☐ No ☐ if yes please explain:
_____
_____

Quality of Relationship:

☐ Great ☐ Good ☐ Fair ☐ Poor

Child Name: _____ Age: _____ ☐ Deceased ☐ Living

If deceased cause of Death? _____

Substance Abuse? ☐ Yes ☐ No if yes please explain:
_____
_____

Quality of Relationship:

☐ Great ☐ Good ☐ Fair ☐ Poor

Legal issues? ☐ Yes ☐ No If yes please explain: _____

Employed? ☐ Yes ☐ No Place of Employment: _____

How long at present position?
_____

Do you have any pain? _____

Memory issues/ Examples:

_____

_____

Do you believe in a higher power? ☐ Yes ☐ No

Participate in Organized Religion? ☐ Yes ☐ No

What provides you with strength and hope?

_____

_____

_____

Family History:

☐ Anxiety ☐ Depression ☐ Anger ☐ Addiction (Drugs/Alcohol)

☐ Withdrawn ☐ Constricted ☐ Hostile ☐ Other Mental Illness

How has your lifestyle background affected you?

_____

_____

Education Highest grade?

_____

_____

Do you want to go back to school?

_____

_____

_____

Who do you look to for support?

_____

Any thoughts or Intentions of Suicide or Homicide?

_____

_____

_____

Therapists Signature: _____ Date: _____

Clients Signature: _____ Date: _____