Marta Miranda, Psy.D.

Licensed Psychologist

Mariposa Therapy & Assessment, PLLC ⬩ 3429 Fremont Place North #310 ⬩ Seattle WA 98103

206-486-2656 ⬩ Fax 206-547-5298 ⬩ [dr.mjlmiranda@gmail.com](mailto:dr.mjlmiranda@gmail.com)

NPI: 1548676331 ⬩ EIN: 83-0702801 ⬩ License: PY60498191

⬩ ⬩

**New Client Intake Form**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

Gender Identity:  Agender  Female  Gender non-conforming  Genderqueer

Male  Non-binary  Transgender  Transgender Male  Transgender Female

Intersex  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation:  Heterosexual  Gay  Lesbian Bi-Sexual  Pansexual

Queer  Questioning  Asexual  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I call this number? Y N Leave a message? Y N

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I call this number? Y N Leave a message? Y N

**Employer Information**

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May I call this number? Y N Leave a message? Y N

**Insurance Information**

Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical and Referral Information**

Name of Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By whom were you referred?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship?\_\_\_\_\_\_\_\_\_\_\_\_\_

**Household Information**

Spouse/Partner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Others in Home: | Gender | Age | Relationship to you |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Emergency Contact**

If emergency, contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Living? | Age | Illness or Cause of Death |
| Father: | Y N | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother: | Y N | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brother/Sister: | Y N | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brother/Sister: | Y N | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Main Concerns**

Please list the major problems with which you would like help in therapy and rate the severity of each one according to the scale below:

Couldn’t

Be Worse

No

Concern

2

4

1

3

5

7

6

8

9

10

Moderate

Concern

Mild

Concern

Severe

Concern

|  |  |
| --- | --- |
| Concerns | Rating |
| 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Briefly describe what motivated you to seek therapy at this time (rather than some time earlier or later):

**Health/ Medical Issues**

1. Do you have any serious medical conditions? Y N (if yes, please describe)

2. How would you rate your overall health?  Excellent  Good  Fair  Poor

3. Please list any medication (including dosages) that you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. How many:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Visits to physician in past year: | \_\_\_\_\_\_\_ | Sick days in past year: | \_\_\_\_\_\_\_\_ |  |
| Therapy sessions, ever | \_\_\_\_\_\_\_ | Cigarettes: Packs/day | \_\_\_\_\_\_ |  |
| Alcohol: Drinks/day | \_\_\_\_\_\_\_ | Caffeine: Cups/day | \_\_\_\_\_\_ |  |

5. Mark all that have resulted from your use of alcohol/ drugs:

|  |  |  |  |
| --- | --- | --- | --- |
| traffic ticket/violation | fight with a friend | | financial problems |
| ruined a relationship | blackouts | |
| work or school problems | | physical violence |

**Current Stressors**

Listed below are some of the sources of stress that clients sometimes feel. Please circle the number that represents the amount of stress you currently feel in each area. (1= very little stress; 10= very high stress):

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | |  | | | | |
| 1. Work or school | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. Personal relationships | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. Family of origin issues | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. Parenting responsibilities | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5. Financial concerns | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6. Legal concerns | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7. Health concerns | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 8. Sexual concerns | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 9. Self-esteem | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 10. Body-image | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11. Grief/ recent losses | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Background**

Education History

Highest grade or degree completed in school\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any difficulties with learning?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In my family, there is a history of (mark all that apply):

|  |  |
| --- | --- |
| alcoholism | physical abuse |
| sexual abuse | emotional abuse |
| eating disorders | substance abuse (other than alcohol) |
| depression | suicide attempts |
| completed suicide | hospitalization for psychiatric reasons |

|  |  |  |  |
| --- | --- | --- | --- |
| Are you in an abusive relationship? | Yes | No | Somewhat |
| Have you ever had an unwanted sexual experience? | Yes | No | Somewhat |
| Have you tried harming yourself in the past? | Yes | No | Somewhat |
| Have you harmed others in the past? | Yes | No | Somewhat |

Please place a check mark beside the following feelings or symptoms that have been present for you in the last two weeks and place two check marks next to those items that are most pronounced for you.

**Feelings/ Symptoms**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Change in appetite |  | Headaches |
|  | Significant weight gain |  | Racing heart |
|  | Significant weight loss |  | Sweating |
|  | Feel agitated or restless |  | Shortness of breath |
|  | Feel slowed down or sluggish |  | Fear of choking |
|  | Feel guilty a lot |  | Chest pain |
|  | Unable to concentrate |  | Nausea |
|  | Withdrawing from other people |  | Dizziness |
|  | Withdrawing from your usual activities |  | Fear of losing control |
|  | Thoughts of death or dying |  | Fear of dying |
|  | Thoughts of suicide |  | Numbness |
|  | Intentions of suicide |  | Chills or hot flashes |
|  | Loss of energy |  | Feeling detached from self |
|  | Feel hopeless about the future |  | Muscle tension |
|  | Feel irritable |  | Unwanted repetitive thoughts |
|  | Depressed mood |  | Unwanted repetitive habits |
|  | Feel very angry at others |  | Spending money excessively |
|  | Trouble controlling your temper |  | Drinking excessively |
|  | Thoughts of harming someone else |  | Taking risks you regret later |
|  | Intentions of harming someone else |  | Afraid of rejection |
|  | Hearing voices |  | Easily influenced by others |
|  | Seeing things others don’t see |  | Feelings get hurt easily |
|  | Easily distracted |  | Have trouble expressing feelings |
|  | Disorganized |  | Have difficulty trusting others |
|  | Procrastinate often |  | Afraid of making mistakes |
|  | Impatient |  | Feel nobody understands you |
|  | Unhappy with weight/appearance |  | Feel talked about or made fun of |
|  | Loss of close relationship |  | Feel like you don’t have close friends |
|  | Wonder whether to stay in a relationship |  | Feel inferior |
|  | Purposely cut or hurt your body |  | Feel empty |
|  | Feel overwhelmed by your emotions |  | Feel anxious |
|  | Sudden shifts in mood |  | Distressing dreams |
|  | Sleep problems |  | Body aches/ pains |
|  | Food binging |  | Unable to enjoy life |
|  | Food purging |  | See no future |
|  | Difficulty making decisions |  | Worry a lot |
|  | Difficulty finishing projects |  | Menstrual problems |

**Worst and Best Times in Life**

Worst time in life (Please briefly describe):

Who helped you through it?\_

Best time in life (Please briefly describe

What have you done that you are most proud of?

What are your strengths (how do you cope) when times are hard?

**Thank you for the effort you put into completing this questionnaire.**