INTAKE FORM

Name_____ Home Phone_____

Address_____ Work Phone_____

City_____ Zip_____ Occupation/employer_____

Your Age_____ Date of Birth_____ Social Security #_____

Insurance Company_____

Spouse_____ Spouse's Age_____ & Occupation_____

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Please rate your general satisfaction with life at present (circle one)
very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied

Please rate your level of satisfaction in present marriage/significant relationship
very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied

Who referred you to therapy? _____

Have you had prior experience in counseling? Yes ( ) No ( ) If yes, please describe with whom, when, how long, and for what: _____

_____

What are the three most significant problems you face currently?

1._____

2._____

3._____

Is there anything in particular that you want the therapist to know about you or your situation?

_____

Present Marriage (or Significant Relationship)

Years known each other_____ Years married_____ Date married_____

Children of this marriage (names/ages) Stepchildren (names/ages)

_____ _____

_____ _____

_____ _____

Have you been married before? _____ **(If one or more prior marriage(s), please list on the back)**

Family of Origin (Parents & Siblings)

Father's name_____ Age_____ Mother's name_____ Age_____

Occupation_____ Occupation_____

Present state of health _____ Present state of health_____

If deceased, year/cause_____ If deceased, year/cause_____

Parents still together_____ divorced_____ remarried_____

Brothers & Sisters	Age	Marital status	Occupation	Location
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Extended and Immediate Family History (Please check those which apply)

Divorce_____ Alcohol/substance abuse_____ Physical abuse_____ Sexual abuse_____

Depression_____ Anxiety_____ Suicide_____ Mental illness_____

Other_____

Current/Recent Mood (Please check)

Anxiety____ Fear____ Sadness____ Grief____ Anger____ Irritability____ Happy____
Impatience____ Calm____ Numb____

Any changes or concerns regarding the following? (Please check those which apply)

Finances_____ Legal Matters_____ Work/Job_____ Education/School_____ Moving_____
Marital Status_____ Parenting_____ Concentration_____ Memory_____ Energy_____
Health/Illness_____ Surgery/Injury_____ Grief/Loss_____ Addition of a Family Member_____
Family Member Leaving Home_____ Sexual Activity____ Sleep Habits_____ Eating Habits_____
Caffeine Intake_____ Tobacco Use_____ Alcohol Use_____ Drug Use_____

Your Personal Health

Identify any allergies, significant health problems, or surgeries that you have had, or currently have:

_____

Do you use any medications? Yes ( ) No ( ) Any drug allergies? Yes ( ) No ( )
If yes, please describe_____

Name of your physician_____

Are you careful about your diet? Yes ( ) No ( )
Do you exercise regularly? Yes ( ) No ( )

Other

Years of Education _____

Is Spirituality/Religion important to you? Yes ( ) No ( )

Do you attend (or have you attended) any Self Help Groups? Yes ( ) No ( ) _____

Who do you consider as your greatest support?_____

What do you consider your greatest strengths?_____

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I, _____, understand and agree to pay costs incurred, including those not covered by my insurance or my co-pay, as agreed upon with therapist during initial session. I understand I am responsible for sessions not cancelled 24 hours in advance. I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment, when necessary.
Re: CONFIDENTIALITY, I understand that my sessions are confidential unless I sign a release, except for the above authorization to the insurance company. I also understand that there are exceptions by law to the privilege of confidentiality. If I say I am going to harm myself or another person, my clinician may report this to the appropriate persons. If I have knowledge of abuse or neglect of a child, elderly person or disabled person, and I tell the clinician, she is obligated to report this to a state agency for follow-up. If a judge subpoenas my records, my clinician must comply. My signature below confirms that I have read and agree to the above and that I give my consent for treatment to the clinician listed herein.

Signature _____ Date _____

Please print name _____ Witness _____

PAST AND PRESENT HISTORY

Put an "X" in the box which indicates health /illness status for you and your family in the present or past.

	HEALTH															
	GOOD	POOR	DIED	DEPRESSION	SUICIDE	ALCOHOL ABUSE	DRUG ABUSE	SCHIZOPHRENIA	PSYCHOSIS	SEVERE ANXIETY	PANIC ATTACKS	NERVOUS BREAKDOWN	HOSPITALIZATION FOR MENTAL ILLNESS	OTHER
Yours (patient)														
Father														
Mother														
Brothers and Sisters														
Spouse														
Children														
Your Mother's Mother														
Your Mother's Father														
Your Father's Mother														
Your Father's Father														