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Intake Form

Today's Date: ________________

Your Name: ____

Birth date: __________________

Home phone: _____________________________ Work phone: ___________________________

Cell phone: _______________________________ email: _______________________________

Home Address: ____
Number and Street

____
City, State and Zip

Mailing Address if different from above: ____
Number and Street

____
City, State and Zip

Which phone number, email or address do you give permission to receive a message, email, or other correspondence? ____

Highest Education Received: ____

Occupation: ____

Relationship Status:

- ❑ Single
- ❑ Married/Date: _____________
- ❑ Living with Partner/Date: _____
- ❑ Separated/Date: ___________
- ❑ Widowed/Date: ____________
- ❑ Divorced/Date: ____________
- ❑ Remarried/Date: ____________
- ❑ Other/Date: _______________

Name of Spouse/partner: ____

Birth date: ________________

Home phone: _____________________________Work phone: _______________________

Cell phone: ______________________________ Email: ____________________________

Address: ____
Number and Street

____
City, State and Zip

Names of children (if any):
1. ____Birth date: ________
2. ____Birth date: ________
3. ____Birth date: ________
4. ____ Birth date: ________

Local person to contact in the event of an emergency:

Name: _______________________________________ Relationship: __________________

Phone Number: ____________________

Family doctor: ________________________________ phone: ______________________

Please list any illnesses or medical conditions: ______________________________________

____

____

Are you currently taking any medications? _______ yes ________ no

If yes, what and for what condition(s): ____

____

Have you ever, or are you currently involved in any kind of therapy, counseling or other mental health treatment at another setting or clinic such as (please check all those that apply):

- ❑ marital therapy
- ❑ family therapy
- ❑ individual therapy
- ❑ group therapy
- ❑ in or out patient treatment for drugs or alcohol
- ❑ in or out patient therapy for an eating disorder
- ❑ in or out patient therapy for any psychological or emotional issues

Where and with whom? ____

____

When? _____________________Was the experience helpful? ___________________________

In what way was the experience either helpful or not? ___________________________________

____

Your reason for seeking therapy today: ____

Please check any of the boxes that you are concerned about or would like to discuss:

- ❑ accident or injury
- ❑ addiction
- ❑ alcohol or drugs
- ❑ anger
- ❑ anxiety
- ❑ bereavement
- ❑ career goals
- ❑ children
- ❑ chronic illness
- ❑ communication
- ❑ conflict resolution
- ❑ depression
- ❑ disturbing or troubling thoughts
- ❑ divorce or separation
- ❑ eating concerns or disorder
- ❑ faith
- ❑ financial concerns
- ❑ gender identity
- ❑ grief
- ❑ hopelessness
- ❑ infertility
- ❑ in-laws
- ❑ insomnia
- ❑ job
- ❑ loss of loved one
- ❑ marriage difficulties
- ❑ men's issues
- ❑ motivation
- ❑ parenting
- ❑ pregnancy
- ❑ pregnancy loss
- ❑ relationships
- ❑ school difficulties
- ❑ self-esteem
- ❑ sexual difficulties
- ❑ special needs
- ❑ spirituality
- ❑ stress
- ❑ suicidal thoughts
- ❑ trauma
- ❑ weight
- ❑ women's issues

What do you hope to accomplish in therapy? ____

____

____

Is there anything else that you would like me to know before we begin?____________________

____

____

Name of person who referred you to our office?____