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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 issu

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?_____