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Licensed Marriage and Family Therapist, Lic. MF24093

Intake Form

Please provide the following information and answer the questions below. Please note: the information that you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Patient Name:_____ _____
Last First MI

Address:_____

City:_____State_____Zip_____

Birth Date: _____/_____/_____ Age:_____ Gender: ☐ Female ☐ Male

Patient SS#_____/_____/_____

Home Phone: ( )_____May we leave a message? ☐ Yes ☐ No

Cell Phone: ( )_____May we leave a message? ☐ Yes ☐ No

Email: _____May we email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Name of parent/ guardian (if under 18):

Name:_____ _____ _____
Last First MI

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse or Partner and age: _____

Please list and children/age:

Names	Age	Living with you?

Insurance (if any)_____

Subscriber's Name_____DOB_____

Policy#_____Group#_____

Subscriber's SS# _____/_____/_____

How you found us / referred by:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No
☐ Yes, previous therapist/practitioner:_____

Are you currently taking any prescription medication?
☐ Yes
☐ No
Please list with dose:_____

1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

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3. How many times a week do you generally exercise?_____
   What types of exercise do you participate in?_____

4. Please list any difficulties you experience with your appetite or eating patterns:

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5. Are currently experiencing overwhelming sadness, grief or depression?

☐ Yes

☐ No

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

☐ Yes

☐ No

If yes, when did you begin experiencing this?_____

7. Are you currently experience any chronic pain?

☐ Yes

☐ No

If yes, please describe_____

8. Do you drink alcohol more than once a week?

☐ Yes

☐ No

9. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc…)

Please Circle and List Family Member

Alcohol/Substance Abuse	☐ Yes Whom:_____
Anxiety	☐ Yes Whom:_____
Depression	☐ Yes Whom:_____
Domestic Violence	☐ Yes Whom:_____
Eating Disorder	☐ Yes Whom:_____
Obesity	☐ Yes Whom:_____
Obsessive Compulsive Behavior	☐ Yes Whom:_____
Schizophrenia	☐ Yes Whom:_____
Suicide Attempts	☐ Yes Whom:_____
Sexual Addiction	☐ Yes Whom:_____

ADDITIONAL INFORMATION:

1. Are you currently in a romantic relationship? ☐ No ☐ Yes
   If yes, for how long?_____
   On a scale of 1 to 10, how would you rate your relationship?_____

2. What significant life changes or stressful events have you experienced recently?

_____

_____

3. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

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4. Do consider yourself to be spiritual or religious?

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5. What do you consider to be some of your strengths?

_____
_____
_____
_____

6. What do you consider to be some of your weaknesses?

_____
_____
_____
_____

7. What would you like to accomplish out of your time in therapy?

_____
_____
_____
_____
_____
_____