

Intake Form

Name: _____ Address: _____

City: _____ State: _____ Zip code: _____

Phone # _____ Cell phone: _____ Email: _____

Last four of SS# _____ Date of Birth: _____ Age: _____ Male Female

Employer: _____ Occupation: _____

Please check any if reasons listed below which resulted in you coming to therapy today?

- Depression Anxiety Alcohol Drugs Marital Issues Family Counseling
- Relationship Enhancement Improvement Sexual Relations Abuse Sexual/Physical Individual Counseling
- Pre- Marital Counseling Communications Difficulties Difficulty with Death Divorce Counseling
- Other: _____

History:

- Anxiety Depression Anger Addiction (Drugs/Alcohol)
- Withdrawn Constricted Hostile Other Mental Illness

What are your current symptoms?

How long have you experienced your current symptoms?

What made you come to treatment now?

What do you expect from Treatment?

Relationship Status:

Memory issues/ Examples: (Schizophrenia) (Alzheimer's) (Meningitis) (Stroke) (Trauma) (Injury) (Infection) (Medication) (Other)

Do you believe in a higher power? Yes No

Participate in Organized Religion? Yes No

What provides you with strength and hope?

Self-harm? Yes No Sometimes

Family History:

Anxiety Depression Anger Addiction (Drugs/Alcohol)
 Withdrawn Constricted Hostile Other Mental Illness

How has your lifestyle background affected you?

Education Highest grade?

Do you want to go back to school?

Who do you look to for support?

Any thoughts or Intentions of Suicide or Homicide?

Emergency Contact: _____ Relationship: _____

Address: _____

Phone Number: _____

Relationship Status:

- Single Cohabiting (Living Together) Divorced Separated Widowed
 Significant Other Remarried (After Divorced) Remarried (After Death) Married (First)

Significant others name:

If deceased cause of Death?

Substance Abuse? Yes No if yes please explain:

Quality of Relationship:

- Great Good Fair Poor

Child Name: _____ **Age:** _____ Deceased Living

If deceased cause of Death?

Substance Abuse? Yes No if yes please explain:

Quality of Relationship:

- Great Good Fair Poor

Legal issues? Yes No If yes please explain: _____

Employed? Yes No Place of Employment: _____

How long at present position?

Do you have any pain? _____

Medical Problems?

Any Medications ?

Primary Physician: _____

Substance Abuse: Yes No

Have you ever been in treatment facility for substance abuse: Yes No

If yes above please explain:

Mothers Name: _____ Age: _____ Deceased Living

If deceased cause of Death? _____

Substance Abuse? Yes No if yes please explain:

Quality of Relationship:

Great Good Fair Poor

Fathers Name: _____ Age: _____ Deceased Living

If deceased cause of Death? _____

Substance Abuse? Yes No if yes please explain:

Quality of Relationship:

Great Good Fair Poor

Therapists Signature: _____ Date: _____

Clients Signature: _____ Date: _____

TREATMENT AGREEMENT