Intake Form

Name: _____ Today's Date: _____

Address: _____

D.O.B.: _____ Age: _____ Work/School: _____

Cell phone: _____ OK to leave msg? Y / N

Work phone: _____ OK to leave msg? Y / N

Other phone: _____ OK to leave msg? Y / N

Email: _____ OK to send emails? Y / N

Emergency Contact Name/Rel./#: _____

Relationship status: _____ Former/Present Marriage(s) (years): _____

Significant Other's name: _____ Age: _____ Occupation: _____

Children (names/ages): _____

Parents/Caregiver(s) (Age or year of death): _____

Siblings (names/ages): _____

Past/Present Medical Issues/Care (Problems, accidents, hospitalizations, current medication):

_____

General Physician and/or Psychiatrist: _____Last seen: _____

Doctor's Phone(s): _____

Therapy History: Name/Dates: _____

Issues, Process and Outcome of Therapy: _____

Past/Present Alcohol and Drug Use/Abuse (any addiction, AA/NA, etc.):

_____

Family History of Addiction, Mental Illness, Violence/Abuse, Suicide:

_____

Social Support/Community? _____

What brings you joy? _____

What are your hopes/dreams? _____

What brings you to therapy now?_____

Use the space on the back of this form if you need to give further information on any question