# Intake Information

Date:______________________

Name:________________________________________Spouse/Partner's Name:________________________________________

Address:__________________________________________________________City__________________Zip______________

Date of Birth______________________ Age_______

Primary Phone number :______________________________ ☐ Cell ☐ Home OK to leave message? ☐Yes ☐No

Email address__________________________________________OK for paperwork and/or correspondence? ☐Yes ☐No

Insurance Carrier______________________________Insured's name_________________________DOB: ________________

1. Sex ☐ Male ☐ Female

2. Marital/Relationship Status
   - ☐ Single (never married)
   - ☐ Significant Other
   - ☐ Cohabitating (living together)
   - ☐ First Marriage
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Remarried (after divorce)
   - ☐ Remarried (after spouse's death)

3. Current Employment
   - ☐ Full-time
   - ☐ Part-time
   - ☐ Homemaker
   - ☐ Unemployed
   - ☐ Full-time student
   - ☐ Part-time student
   - ☐ Retired

4. Education
   - ☐ Grade school/junior high
   - ☐ Attending/attended high school
   - ☐ High school graduate
   - ☐ Attending/attended college
   - ☐ College graduate
   - ☐ Attending/attended graduate school
   - ☐ Technical school degree
   - ☐ Graduate degree (Masters/doctoral)
   - ☐ Military

5. Children (include biological, adopted, foster, step, etc)

| Name | Sex | Age | Type (bio,step,etc.) | Custody? |
|---|---|---|---|---|
| ________________________________ | ______ | ______ | __________________ | ☐ Yes ☐ No |
| ________________________________ | ______ | ______ | __________________ | ☐ Yes ☐ No |
| ________________________________ | ______ | ______ | __________________ | ☐ Yes ☐ No |
| ________________________________ | ______ | ______ | __________________ | ☐ Yes ☐ No |

6. Race/Ethnicity
   ☐ Caucasian ☐ Native American ☐ Latin or Spanish ☐Asian ☐African American ☐Multiracial ☐Other ___________________

7. Language spoke in the home other than English _____________________________________

8. Primary Care Info: (Name and Phone #) ____________________________________________________________________________

   If currently under physician's care please indicate what for (and Physician's or Psychiatrist's name if different than PCP)

   ____________________________________________________________________________________________________________

   List current medications and amounts ______________________________________________________________________________

   ____________________________________________________________________________________________________________

   Do you want us to coordinate care with your physician? ☐ Yes ☐ No

# Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- ☐ Depression or Anxiety
- ☐ Alcohol or other drug abuse
- ☐ Marital Problems
- ☐ Communication Difficulties
- ☐ Improved Sexual Relations
- ☐ Sexual Orientation Questions
- ☐ Child Adjustment/Parent Conflict
- ☐ Thinking of harming self or others
- ☐ Abuse (physical/verbal/sexual)
- ☐ Difficulty with loss or death
- ☐ ______________________________
- ☐ Blended Family Adjustment
- ☐ Divorce
- ☐ Life/Medical Stressors
- ☐ Family Counseling
- ☐ Relationship Enhancement
- ☐ Adoption
- ☐ Individual Counseling/Self growth
- ☐ Pre-marital Counseling
- ☐ School/Work adjustment problems
- ☐ Weight/Body Image/Eating behaviors
- ☐ ______________________________

What event happened which made you think "I am (we are) calling a therapist?" ______________________________

______________________________________________________________________

______________________________________________________________________

Please explain what you are hoping to achieve through the use of counseling services:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

What behaviors would you like to change? ______________________________________________

______________________________________________________________________

______________________________________________________________________

How would you know if things were getting better? ________________________________________

______________________________________________________________________

______________________________________________________________________

Specific Goals identified after first session (to be completed with therapist). Plan Review Date: 6 months from intake

☐ Child ☐ Family ☐ Couple ☐ Individual (with or without collaterals)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

| ______________________________ | ______________________________ | ______________ |
|---|---|---|
| Client's or Legal Representative's Signature | Client's or Legal Representative's Name (print) | Date |

| ______________________________ | ______________________________ | ______________ |
|---|---|---|
| Clinician's Signature | Clinician's Name (print) | Date |

Have you received prior counseling? Yes or No related to these problems?______Other __________

**If yes and related**, was it: Outpatient Inpatient (including hospitalization)

When:_____________________________Where:_________________________________________________

Counselor/Doctor:________________________________Length of Treatment:_________________________

Problem(s) treated: ________________________________________________________________________

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the Same ☐ Somewhat Worse ☐ Much Worse

**If Other**, was it: Outpatient Inpatient (including hospitalization)

When:_____________________________Where:_________________________________________________

Counselor/Doctor:________________________________Length of Treatment:_________________________

Problem(s) treated: ________________________________________________________________________

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the Same ☐ Somewhat Worse ☐ Much Worse

Family History of mental illness? (if yes, please describe)______________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

How were you referred to me? ___________________________________________________________________

Person to contact in case of an emergency (*limited information will be given, enough to get you the care you may need at that time):*

Name_________________________________________Relationship ______________________________

Phone _______________________________________