INTAKE

Date: _____

Name (Last, Middle Initial, First):

_____

Street Address:

_____

City: _____ **State:** _____

Home phone: _____ **Cellphone:**_____

E-mail: _____

Please indicate the means by which you prefer to be contacted. You may check more than one: Phone: _____ Text: ____ E-mail: _____ Regular Mail: ____. If you would prefer to be contacted at a phone number, e-mail, or address other than what is listed above, please provide that information here:

_____

_____

Date of Birth: _____ **Age:** _____

Gender:

Woman: ___ Man: ___ Transgender: ___ Transman: ___ Transwoman: ___ Gender Nonconforming: ___ Other: _____

Orientation:

Straight: ___ Gay: ___ Lesbian: ___ Bisexual: ___ Asexual: ___

Queer: ___ Questioning: ___ Other: _____
Prefer not to answer: ___

What type of services are you currently seeking? Please mark an "X" by the type of services you are seeking.

Individual therapy Marital/Couples therapy

Family therapy Group Therapy

Other (describe) Unsure:

Goals of Treatment:

What compelled you to seek therapy at this time?

Describe your current concerns, issues, or problems that you hope to resolve:

What do you hope to gain from therapy?

Relationship Status (Please check all that apply):

Are you presently married or involved in a relationship?

Yes_____ No_____

If you answered yes, how would you describe your current level of satisfaction with the relationship?

_____
_____

Have you married previously? If yes, when?

_____
_____

Name of the individual whom you identify as your significant other:

_____
_____

If you are married, or in a relationship, rate your level of contentment/ happiness/satisfaction in the relationship on a scale of 1 to 10 (Number 1 indicates a sense of being very or extremely happy and the number 10 indicates a sense of being extremely unhappy).

Briefly explain the rating you give in the space provided:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

On a scale of 1 to 10, describe your level of commitment to your relationship (Number 1 indicates a sense of being very committed and the number 10 indicates a sense of not feeling at all committed). Briefly explain the rating you give in the space provided:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Source of Income:

Employment: _____ Unemployment: _____

Spouse/Significant Other: _____ Social Security: _____

Short Term-Disability: _____Other: _____

Current Employment Status (Please check all that apply):

Working Full-Time: _____ Part-Time: _____ Retired: _____

On medical leave: _____

Unemployed and looking for work: _____

Not employed due to other reasons _____Full-Time Student: _____

Part-Time Student: _____

Education Information: (Please check the highest level of education/degree you have received):

Elementary, Grades 1-8: _____ Some High School (no diploma): _____

High School Diploma/GED: _____ Some College (no degree): _____
Technical/Trade School Graduate: _____ Associate's Degree: _____
Bachelor's Degree: _____ Master's Degree: _____

Professional Grad Degree (MD, JD):_____ Doctoral Degree:_____

Military History:

Currently on active duty: _____ Served in Military (please circle length of time served) for: _____number of weeks, months, or years.

Never served in the military: _____

If you have served in the military were you ever deployed, yes or no?

Yes: _____ No: _____

If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Legal History:

Have you been ordered by the court to participate in this therapy, yes or no?

Yes: ____ No: ____If yes, you may be required to supply supporting documentation such as a copy of the court order.

Are you currently involved in any kind of litigation or legal dispute, yes or no?

Yes: _____ No: _____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):

_____
_____
_____
_____
_____
_____

Emergency Contact Information: (Who you prefer me to contact in case of an emergency)

Name: _____

Relationship: _____Phone number: _____

Email: _____

Referral Information:

Were you referred? Yes: _____ No: _____ I f referred, by whom?

_____
_____
_____
_____

Payment Information:

Please indicate how you intend to pay for treatment:

Cash: ____Check: ___ Credit Card: ___Employee Assistance Program:____
Insurance: _____ Third-Party: _____.

If a third-party will be paying for your treatment please provide the following information:

Name of the person paying for your therapy: _____
Your Relationship to this person: _____
_____

Contact Information for this person:
_____

If you are planning to use health insurance, please provide the following information:

Name of Insurance Company: _____

_____

Subscriber's Name: _____

_____

Insured's ID number: _____

Group Policy Number: _____

Co-Payment Amount: _____

Insurance Claim's Mailing Address:
_____
_____

Previous Mental Health Treatment History:

Have you participated in therapy? Yes: _____ No: ____ If YES, please complete the information below:

Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
_____

Phone Number: _____

Email: _____

Street Address: _____

City: _____ State: _____

Dates of treatment:
_____

Focus of treatment:
_____

_____

Have you ever been hospitalized because of a mental health disorder, yes or no?

Yes: _____ No: _____. If you indicated that you have been hospitalized for a mental health disorder, please complete the following information:

Reason for hospitalization:
_____
_____

Was hospitalization voluntary or involuntary? Please check:

Voluntary: _____ OR Involuntary: _____

How long was your hospitalization?

_____

Where were you hospitalized?

_____

_____

Course of treatment during hospitalization:

_____

_____

_____

Provide the name of the providers who treated you below. Please indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Licensed Therapist).

Name: _____

Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):

_____

Phone Number: _____

Dates of treatment:_____

Current Mental Health Treatment:

Are you currently participating in therapy or counseling?

Yes: ____ No: _____ If YES, please complete the following information:

Name of Current Provider:

_____

Type of provider:

_____

Phone Number: _____ Email:_____

City: _____ State: _____

Dates of Treatment:

_____

Focus of Treatment:

_____

If you are currently receiving therapeutic services from another psychotherapist, to avoid a duplication of services, it may be necessary for me to contact your current psychotherapist to coordinate care. You may be required to sign and "Authorization for Release of Confidential Information" form which will be provided to you and maintained as part of your clinical record long with a copy of this patient intake form.* Please Initial: _____

If you are currently under the care of a psychiatrist, are you taking any prescribed psychiatric medication(s), yes or no? Yes _____ No_____. If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects in the space below.

For example: "Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)."

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

***California Civil Code Section, 56.10 states that information may be disclosed to "providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient" without the patient's consent. By initialing, you acknowledge and understand that I may contact either your current or former mental health care and/or medical providers only to discuss issues relevant to your diagnosis and treatment without your consent. Initial: _____**

Medical Treatment Information:

Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition, yes or no? Yes: _____ No: _____. If you currently have a medical condition, please provide the following information:

Current medical condition:

_____

How long have you had the condition?

_____

Is it a medically treatable condition, yes or no? Yes: _____No: _____
If, it is not a medically treatable condition (i.e., palliative care), please describe:

_____
_____
_____
_____
_____ If you are currently taking prescribed medications for the condition please describe the type of medication, indicate how long you have been taking the medication, and any side effects.

For example: "High blood pressure medication (type of medication); 2 years (length of time on medication); Drowsiness (example of a side effect).

_____
_____
_____
_____
_____
_____
_____
_____
_____

Trauma History:

Have you been – or are you currently being – emotionally, physically, or sexually abused?

Yes _____ No _____ Prefer not to answer _____. If you checked "Yes," you may use the space below to describe the underlying circumstances:

_____
_____
_____
_____
_____
_____

Family of Origin Information:

Were you adopted, yes or no? Yes: _____ No: _____.

If you were adopted, at what age were you adopted? _____ .

If you were adopted, do you have a relationship with your birth mother and/or father, yes or no? Yes: _____ No: _____If yes, please describe the nature of the relationship. For example, explain how the relationship with your biological parent(s) was established, how old you were at the time the relationship began, the frequency of contact you had or currently have, and the nature of the relationship:

_____
_____
_____
_____
_____
_____

If you were adopted/or not, what type of relationship do you/did you have with your parents?

_____
_____
_____

Do you have any biological siblings, adopted siblings, step siblings, or half siblings, yes or no? Yes: ____ No: ____. If you have any siblings, how many? _____. In the space provided below, list the name and ages of each of your siblings and briefly describe the nature of your relationship as being "close," or "not close," or "estranged," or any other word that describes the nature and extent of your relationship with your siblings.

Which of the following statements most resonates with you:

• My parents were present during my entire childhood, yes or no?

Yes: _____No: _____.

Explain:_____

Which of the following describes your childhood family experience:

• _____ It was an outstanding home environment

• _____ It was a normal home environment

• _____ It was a chaotic home environment

• _____ Prefer not to answer

If you indicated that your home environment was chaotic, please explain. For example, you may have witnessed physical/verbal/sexual abuse towards others, or you may have experienced physical/verbal/sexual abuse from others:

_____
_____
_____
_____
_____
_____
_____

Mental Health/Risk Assessment:

Please identify if you have experienced any of the following and whether this is a past, current, or reoccurring issue:

• Suicidal Thoughts.

Past:_____ Present:_____

Reoccurring:_____
_____

• Thoughts of wanting to intentionally harm myself.

Past:_____ Present: _____ Reoccurring: _____

• Thoughts of wanting to intentionally cause harm to someone else.

Past:_____ Present: _____ Reoccurring: _____

• Post-Traumatic Stress.

Past:_____ Present: _____ Reoccurring: _____

If you are currently experiencing any thoughts of either harming yourself or someone else please answer the following questions:

How long have you had these thoughts?

_____
_____

How frequently do you have these thoughts?

_____
_____
_____
_____

Do you have a plan and/or the means to carry out either the threat of harm to yourself or to someone else, yes or no? Yes: _____ No: _____If yes, please explain:

_____
_____
_____
_____
_____

Have you ever tried to harm yourself or anyone else in the past, yes or no? Yes: ____ No: ____If yes, please explain:

_____
_____
_____
_____

Is there anything that would stop, or prevent, you from harming yourself or someone else, yes or no? Yes: ____ No: ____ If yes, please explain?

_____
_____
_____
_____

If you indicated that there is not anything that would prevent you from harming yourself or someone else, please identify how likely it is that you might actually harm yourself or someone else:

Imminently likely: _____ OR Not at all likely: _____

Alcohol/Substance Use History:

Family Alcohol Abuse History: To the best of your knowledge, please indicate which of the following family member(s) struggles or struggled with alcohol/substance abuse or addiction:

Father: _____ Mother: _____Grandparent(s): _____

Sibling(s):_____

Stepparent(s): _____ Uncle(s)/Aunt(s):_____

Spouse/Significant Other: _____ Children: _____

Please indicate your substance use status:

No history of use: _____ Actively using alcohol or drugs: _____

In early full remission: _____ In early partial remission: _____

In sustained full remission: _____

In sustained partial remission: _____

If you indicated that you have an alcohol/substance abuse or addiction history, please identify the types of treatment you have participated in, or are currently participating in, and how long you have been participating in the particular treatment.

Outpatient treatment:

_____

_____

Inpatient treatment:

_____

_____

12-Step Program:

_____

_____

Stopped using on my own:

_____

_____

Other Method:

_____

_____

Was the above treatment method effective? Please explain:

_____

_____

_____

Please identify the type(s) of substances you are using, how frequently you use the substance, and how long you have been using the substance, and your frequency of use (i.e., daily, as needed, no regulation of use, etc.)

Opioid(s): _____ Classification: _____ Length of use: _____

Frequency of use: _____

Heroin: _____ Length of use: _____ Frequency of use: _____

Cigarettes/Tobacco: ___ Length of use: ___ Frequency of use: _____

Alcohol: ____ Length of use: _____ Frequency of use: _____

Amphetamines: ____ Length of use: _____Frequency of use: _____

Barbiturates: ____Length of use: _____ Frequency of use: _____

Cocaine: _____ Length of use: _____ Frequency of use:_____

Crack: _____ Length of use: _____ Frequency of use: _____

Hallucinogens: _____Length of use: ____ Frequency of use: _____

Inhalants: _____ Length of use: _____Frequency of use: _____

Marijuana: _____ Length of use: ____ Frequency of use: _____

Other: _____ Length of use: ____ Frequency of use:_____

If you have indicated that you have used, or are currently using substances, please indicate what side effects and or consequences you experienced or are experiencing as a result of the use.

Overdose: _____ **Suicidal Impulse:** _____ **Depression:** _____
Anxiety: _____ **Blackouts:** _____ **Loss of control:** _____
Medical conditions: _____ **Other:** _____

Please use the space provided to describe any other effects or consequences you have experienced:

_____
_____
_____
_____

Spiritual/Cultural History:

Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:

_____
_____
_____
_____

Do any of the above religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? If so, please describe:

_____
_____
_____
_____

Additional Information

Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events:

_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____

Date: _____