Intake form

Client information

Name_____Date_____

Birth date_____Age_____Sex_____

Religion_____Marital Status_____Race_____

Children, name and age_____

Address_____

City_____State_____Zip_____

Home phone_____Can I leave a VM?_____

Cell phone_____Can I leave a VM?_____

Work phone_____ Can I leave a VM?_____

E-mail_____Can I e-mail you?_____

Who currently resides in your household and what is their relationship to you?_____

_____

What is bringing you into therapy?_____

_____

_____

What are your goals for therapy?_____

_____

_____

Medical History

Current Medical Issues:_____

_____

Arlene Rosen, LMFT
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Current Medications:_____

_____

Previous Medical Issues:_____

_____

Have you sought prior counseling?_____

_____

Are you currently taking or previously taken psychiatric medication?_____

_____

Do you have a history of substance use or abuse? Please list substances and history_____

_____

_____

Have you experienced legal issues? Please list prior or current issues_____

_____

_____

Have you served in the military? If so, which branch and discharge status._____

_____

Is there a history of mental health issues, suicide or domestic violence for yourself or family members? Please list _____

_____

_____

_____

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Are you have trouble sleeping?_____

_____

_____

Have you had or are experiencing sexual issues?_____

_____

_____

What are your strengths?_____

_____

_____

What are your weaknesses?_____

_____

_____

Are you currently employed?_____

_____

_____

What other information may be important for me to know?_____

_____

_____

_____

_____

_____

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