CONFIDENTIAL INTAKE FORM A

Name: ____ DOB: ___/___/___
(First) (M.I.) (Last) [ ] Female [ ] Male
Mailing Address: ____

Home Phone: _____________ Cell #:_________________ Preferred No.__________________
Occupation/Employer: ____ Education: ______________

Emergency Contact: ____

Marital Status (if applies): [ ] married [ ] legal sep. [ ] divorced [ ] separated

No. of prior marriages: _____ Year of last divorce: ___________ Year of recent marriage: ____________

Partner's Name: __________________________ Age: ____ Occupation: _______________________
Total # of Children: ____ Names/Ages of Children living with you: ____________________________
____

Primary Care Physician: ____________________________________ Date of Last Visit: ______________
Location: ____ Tel: _________________________

Stress/Chronic Medical Conditions: ____

Medications:____
Prescribed By: ____

Number of Siblings: _____ Your birth order: _____ Mother's Age: _____ Father's Age: _____
Have you ever been abused? [ ] Sexually [ ] Physically [ ] Emotionally By whom? _____________

History of alcohol, drug, or mental health problems with:
Mother and mother's family? ____
Father and father's family? ____
Brothers and sisters? ____

Situational/Stressors: ____ Veteran? ______

Gender Identity/Orientation:___________________ Religion/Ethnicity:______________________________

Describe Current Use of Nicotine/Alcohol/Drugs:____

Mental Health Treatment History (inpatient/outpatient/dates/providers):______________________________
____
____

What issues/problems do you wish to address in this therapy? ______________________________________
____
____

Please check box if you feel: [ ] sad/hopeless/disinterested in living [ ] at risk of harm to yourself or [ ] to others

Are you satisfied with your sleep? [ ] Yes [ ] No If not, do you have trouble: falling asleep? [ ] Yes [ ] No
staying asleep? [ ] Yes [ ] No
feeling refreshed? [ ] Yes [ ] No

Today's Date: ________________ Your Age: _______

Email Address: ____ Revised: 03/22