INTAKE FORM FOR PSYCHOTHERAPEUTIC SERVICES

Identifying Information

Name: _____ Sex: ____ Birth date: _____ Age: _____
Social Security #: _____ Drivers License #: _____
Home telephone: ( ) _____ - _____ Is it okay to call you there? ____ Leave message? _____
Preferred contact #: ( ) ____ - _____ Other contact number(s)? _____
Residence address (including zip code): _____
_____
Is it okay to send mail to this address? ____ If not, please give us a mailing address (including zip code):
_____
Email: _____ Is it okay to send mail here? _____
Occupation: _____ Work telephone: ( ) ____ - _____
Is it okay to call you at work? ____ Leave message? _____
How did you hear about Family Counseling & Trauma Healing Center, Inc. and/or Beverly Taylor, LMFT?
_____
_____ May we thank him/her for referring you? (Please initial if yes) ___
Please provide the name of someone that we may contact in the event of an emergency concerning you:

_____	_____	_____
Name	Relationship	Telephone

Physical History

Date of your last physical examination: _____
Do you have any serious medical conditions? Yes/No If yes, what? _____
_____ Have you ever had a serious head injury? Yes/No
Have you ever had a stroke, aneurysm, or other neurological insult? Yes/No
What medications do you take regularly? _____
_____
Who is your primary care physician? _____

Social History

Birth place: _____ Number of siblings: _____
Highest grade/degree completed in school: _____ How did you do in school? _____
Have you ever been diagnosed with or suspected of having a learning difficulty or other developmental difficulty? Yes/No If yes, what? _____
Number of times you have been in a committed partnership: _____
Current marital/partnership status: _____
If in a committed relationship, for how long? _____
Number of children you have: _____ Children's ages: _____

CONTINUED ON NEXT PAGE

Client Name: _____ Date: _____

Mental Health History

Have you ever suffered from a mental health concern before now? Yes/No

If yes, what type of problem? _____

Have you ever sought treatment from a mental health care professional before now? Yes/No

If yes, from whom? _____

When and for what? _____

Do you consider the treatment successful? Yes/NO

Are you currently receiving treatment from another mental health care professional? Yes/No

Have you ever been harmed or abused by a mental health care provider? Yes/No

Have you ever filed a complaint or lawsuit against a mental health care provider? Yes/No

Have you ever taken any medication for a mental health concern (e.g., depression, anxiety, etc)? Yes/No

If so, when? _____

If so, what medication(s) and dosage? _____

Alcohol and Drug Use

Have you ever used alcohol or any other non-prescription drug? Yes/No

If yes, do you currently use alcohol or other non-prescription drugs? Yes/No

How often do you use alcohol or other non-prescription drugs? _____

When you use alcohol or other drugs, how much do you consume? _____

Has your alcohol or drug use ever resulted in any problems? Yes/No

Sexual Abuse History

Were you ever sexually abused/assaulted? Yes/No

If so, when? _____

By whom? _____

Did you receive any treatment to help you deal with the experience? Yes/No

Violence and Suicide Risk

Have you ever been in a physical fight with anyone? Yes/No

If you are older than 25 years, have you been in a physical fight since the age of 25? Yes/No

If yes, have you ever used a weapon (e.g., firearm, knife, baseball bat, bottle) in a fight? Yes/No

If yes, have you ever injured another person in a physical fight? Yes/No

Have you ever seriously considered suicide? Yes/No

If yes, are you seriously considering suicide now? Yes/No

Have you ever attempted suicide? Yes/No

If yes, how many times? _____

If yes, by what means? _____

Goals for treatment: (PLEASE LIST AT LEAST TWO)