

INTAKE FORM

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Name: _____ Date: _____

Address (City, State, Zip): _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____

Future Contact (Circle if OK): Phone Home / Work / Cell Mail Home Email

Date of Birth: _____ Age: _____

Marital Status: Single / Married / Divorced / Cohabiting / Widow

Please tell us why you are seeking services at this time.

What do you hope to accomplish from the services you receive?

Please list the family members who are living at your address.

Name	Relationship	Age

Please list any of your children who are not living at your address.

Name	Relationship	Age

Marriage History

Number of Marriages: _____

Date of Present Marriage: _____ Date of Separation, if applicable: _____

Date of Previous Marriage: _____ Date of Separation/Divorce: _____

Reason for Separation/Divorce: _____

Notes: _____

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Please list your family members, including biological and step family members.

Family Member	Name	Age	Marital Status	If deceased, date and cause
<i>Parent</i>				
<i>Parent</i>				
<i>Parent</i>				
<i>Parent</i>				
<i>Sibling</i>				
<i>Sibling</i>				
<i>Sibling</i>				
<i>Sibling</i>				
<i>Sibling</i>				

Were you adopted? Yes / No

Have you or your partner ever had a miscarriage or abortion? Yes / No

How would you describe your relationship with your mother?

How would you describe your relationship with your father?

Have you, or any member of your family, ever been abused physically, emotionally, or sexually? If yes, please describe. _____

Have you ever been a perpetrator of abuse? If yes, please describe. _____

Have you ever been affected by a traumatic event now, or in the past? If yes, please describe.

Education

Were you ever diagnosed with a learning or conduct disorder in school? If yes, please describe.

How far did you go in your education: Grade School / High School / College / Grad School / Vocational / Tech School / Other: _____

Employment

Are you under work / financial stress? If yes, please describe. _____

What types of jobs have you held previously? _____

How long have you been in your present job? _____

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Legal

Have you ever been arrested. If yes, please describe. _____

Are you currently on probation / parole? If yes, please describe. _____

Are you currently involved in any legal actions such as divorce, bankruptcy, or lawsuit? If yes, please describe. _____

Have you ever received a DUI / DWI? If yes, please describe. _____

Medical

Primary Care Doctor: _____

Please list any current and past impairments, illnesses, surgeries, and hospitalizations.

Allergies: _____

How frequently do you exercise? _____

Current Medication

Name of Medication	Dosage	Frequency	Taken as Prescribed?	Date Started	Prescribing Physician	Side Effects

Substance Use Information

	YES/NO	NOTES
Do you smoke or use tobacco?		
How many times a week do you use alcohol?		
How many drinks do you usually consume during each occurrence?		
Have you ever felt the need to cut down on your drinking?		
Do you ever feel guilty about your drinking?		
Have you ever become annoyed at criticism about your drinking?		
Do you ever feel guilty about your drinking?		
Do you ever need a drink in the morning to get going?		

Do you or your family members have a history of alcohol and/or drug dependency? If yes, please describe. _____

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What other drugs, other than alcohol or tobacco, have you experimented with or used regularly, now or in the past? _____

Treatment History

Please list any current and previous counseling and psychiatric treatment for you and/or any family members.

Person Receiving Treatment	Type of Treatment (outpatient, inpatient, residential, chemical dependency, etc)	Service Provider	Dates

Please check past and current symptoms.

Past	Present	Symptom	Past	Present	Symptom
		Addictions – Drugs			Health Problems
		Addictions – Alcohol			Homicidal Thoughts
		Addictions – Gambling			Hopelessness
		Addictions – Sex/Pornography			Hyperactivity
		Addictions – Eating			Impulsivity
		Aggressive Behavior			Isolation
		Anger			Lack of Motivation
		Anxiety/Worry			Learning Problems
		Appetite Changes			Loss/Death of a Significant Person
		Breaking the Law			Marital/Relationship Problem
		Crying Spells			Mood Swings
		Decrease Energy			Physical Complaints
		Depression			School Problems
		Developmental Disabilities			Self-Mutilation
		Difficulty Concentrating			Sexual Problems
		Disobedience			Sleep Changes
		Drugs/Alcohol			Speech/Language Problems
		Eating Disorders			Stress
		Fears			Suicidal Thoughts
		Fighting			Temper Tantrums
		Fire setting			Wets Bed
		Hallucinations			Other:

Thank You!