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Licensed Marriage and Family Therapist
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GENERAL:

Name (Last, Middle Initial, First):
Street Address:_____ City: _____ State: _____
Home Phone: _____ Alternate Phone: _____
Email: _____ Alternate Email: _____

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

Date of Birth: _____ Age: _____

GENDER:

❑ Woman _____ ❑ Man
_____ ❑ Transman:
_____ ❑ 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" or "✓" 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 ❑ Working 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:

❑ Elementary, Grades 1-8 ❑ Some High School (no diploma) ❑ High School/GED
❑ Some College (no degree) ❑ Technical/Trade School Graduate
❑Associates Degree ❑ Bachelor's Degree ❑ Master's Degree
❑ Professional Graduate Degree (i.e., MD, JD, etc.): _____
❑ Doctoral Degree (i.e. PhD, EdD, etc.): _____

MILITARY HISTORY:

❑ Currently on active duty
❑ Served in Military (please circle length of time served): _____Weeks/Months/Years
❑ Never served in the military

If you have served in the military, were you ever deployed? ❑ Yes ❑ No
If yes, please describe your deployment 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 ❑ 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 ❑ No
If yes, please explain (i.e. custody dispute, dissolution proceedings, etc.):

_____
_____
_____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____
Phone number: _____ Email: _____

REFERRAL INFORMATION:

Were you referred? ❑ Yes ❑ No
If 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 is 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: _____

HEALTH INSURANCE INFORMATION:
Name of Insurance Company: _____
Subscriber's Name (Last, First, Middle): _____
Insured's ID Number: _____ Group Number: _____
Co-Payment Amount: _____
Insurance Claim's Mailing Address: _____
_____
Insurance Company Telephone Number: _____

PREVIOUS MENTAL HEALTH TREATMENT HISTORY:
Have you participated in therapy before? ❑ Yes ❑ No
If yes, please complete the information below:

Name of Provider: _____
Type of Provider ❑ Psychiatrist ❑ Psychologist ❑ Therapist
❑ Other: _____
Phone Number: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Dates of Treatment: _____
Focus of Treatment: _____

Name of Provider: _____
Type of Provider ❑ Psychiatrist ❑ Psychologist ❑ Therapist
❑ Other: _____
Phone Number: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Dates of Treatment: _____
Focus of Treatment: _____

Name of Provider: _____
Type of Provider ❑ Psychiatrist ❑ Psychologist ❑ Therapist
❑ Other: _____
Phone Number: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Dates of Treatment: _____
Focus of Treatment: _____

Have you ever been hospitalized because of a mental health disorder? ❑ 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? ❑ Voluntary ❑ 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 of Provider: _____
Type of Provider ❑ Psychiatrist ❑ Psychologist ❑ Therapist
❑ Other: _____
Phone Number: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Dates of Treatment: _____

Name of Provider: _____
Type of Provider ❑ Psychiatrist ❑ Psychologist ❑ Therapist
❑ Other: _____
Phone Number: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Dates of Treatment: _____

Name of Provider: _____
Type of Provider ❑ Psychiatrist ❑ Psychologist ❑ Therapist
❑ Other: _____
Phone Number: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
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 Provider: _____
Type of Provider ❑ Psychiatrist ❑ Psychologist ❑ Therapist
❑ Other: _____
Phone Number: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Dates of Treatment: _____
Focus of Treatment: _____

Name of Provider: _____
Type of Provider ❑ Psychiatrist ❑ Psychologist ❑ Therapist
❑ Other: _____
Phone Number: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
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 an "Authorization for Release of Confidential Information" form which will be provided to you and maintained as part of your clinical record along 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 ❑ No
If you indicated that you are currently taking psychiatric medication(s), please list the type of medication, the specific medication you have been prescribed, the dosage, frequency, the purpose, and any side effects in the table below.

Medication/Rx	Dosage	Frequency	Purpose	Side Effects
For example: Zoloft	50mg	1x/day	Anti-depressant	Insomnia

If you are currently under the care of a psychologist, have you participated in any psychological assessments or tests? c
If you have participated in psychological testing, please list the type of test performed, the specific name of the test, the date(s) the test(s) were administered.

Type of Test	Name of Test	Administration Date
For example: Personality Test	Minnesota Multiphasic Personality Inventory (MMPI-2)	February 1, 2017

***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?

If you have a current medical condition, please provide the following information:

Current medical condition: _____

How long have you had the condition? _____

Is it a medically treatable condition?

If it is not a medically treatable condition, (i.e., palliataive 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, any side effects, and purpose of the medication.

Type of Medication	How Long You've Taken the Medication	Side Effects
For example: High blood pressure medication	2 years	Drowsiness

TRAUMA HISTORY (OPTIONAL):

Have you ever been—or are you currently being—

❑ Emotionally abused? ❑ Physically abused? ❑ Sexually abused?

❑ Prefer not to answer.

If you checked abuses above, you may used the space below to describe the underlying circumstances:

_____

_____

_____

_____

_____

FAMILY OF ORIGIN INFORMATION (OPTIONAL):

Were you adopted? ❑ Yes ❑ No

If yes, do you have a relationship with your birth mother and/or father? ❑ 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, what type of relationship do you/did you have with your adopted parents?

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

Please provide the following information about your parents either (biological/adopted) or stepparent:

Name of Mother: _____
Name of Father: _____
Mother's Occupation: _____
Father's Occupation: _____
Name of Stepmother: _____
Name of Stepfather: _____
Stepmother's Occupation: _____
Stepfather's Occupation: _____

Are either of your parents (biological or adopted, and/or step parents) deceased?
❑ Yes ❑ No

If your parents are deceased, please provide the following information:

- Mother/Stepmother has been deceased for _____ days/weeks/months/years. What was your age at the time of your mother's/stepmother's passing? _____
- Father/Stepfather has been deceased for _____ days/weeks/months/years. What was your age at the time of your mother's/stepmother's passing? _____

Indicate the marital status of your parents (biological/adopted). Check all that apply:

- ❑ Currently married to each other for _____ years
- ❑ Currently separated for _____ years
- ❑ Divorced for _____ years
- ❑ Mother remarried _____ times
- ❑ Father remarried _____ times
- ❑ Mother currently single after being separated/divorced for _____ years
- ❑ Father currently single after being separated/divorced for _____ year
- ❑ Mother is currently involved with someone ❑ Yes ❑ No
  For how long? _____
- ❑ Father is currently involved with someone ❑ Yes ❑ No
  For how long? _____

Do you have any biological siblings, adopted siblings, step siblings, or half siblings?
❑ 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," of 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.
  Explain: _____
  _____
  _____
  _____
- ❑ My parents were present during a part of my childhood.
  Explain: _____
  _____
  _____
  _____
- ❑ My parents were not present at all during my childhood.
  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:

Risk	Past	Present	Reoccurring
Suicidal Thoughts	❑	❑	❑
Thoughts of wanting too intentionally harm myself	❑	❑	❑
Thoughts of wanting to intentionally cause harm to someone else	❑	❑	❑
Post-Traumatic Stress	❑	❑	❑

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 ❑ No

If yes, please explain:
_____
_____
_____

Have you ever tried to harm yourself or anyone else in the past? ❑ Yes ❑ No
If yes, please explain:
_____
_____
_____

Is there anything that would stop, or prevent, you from harming yourself or someone else?
❑ 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 likely at all

ALCOHOL/SUBSTANCE USE HISTORY (OPTIONAL)

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.)

Substance	Length of Use	Frequency
Opiods Classification:		
Heroin		
Cigarettes/Tobacco		
Alcohol		
Amphetamines		
Barbiturates		
Cocaine		
Crack		
Hallucinogens		
Inhalants		
Marijuana		

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 (OPTIONAL)
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:

_____
_____
_____
_____
_____
_____
_____

Client Signature _____ Date: _____

Print Client Name _____