INTAKE FORM

Cecilia Escobedo, LMFT

Please provide the following information for Cecilia Escobedo, LMFT's records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality in our therapy.

Today's date: _____

Last Name: _____First Name:_____ Mid Initials:____

Date of birth: _____

Gender: Male_____ Female_____ Other_____ Preferred Pronoun: _____

Address: _____ City _____ State _____ Zip Code_____

Email address: _____

Home phone: _____ cell: _____ May I leave a message? Yes_____ No_____

Emergency contact: _____Relationship: _____Phone number: _____

Marital status: Single ____ In-a-relationship: _____ Married: ____ Divorced: _____

Number of children: _____

Source of referral: _____

Insurance Information

Insurance Company:_____ Phone: _____

Insurance Identification Number: _____Group Number: _____

Secondary insurance: _____ Phone: _____

Secondary Identification Number: _____ Group Number: _____

Health Information

- Are you currently taking prescribed psychiatric medication? Yes___ No____

If yes, please list: _____

Medical provider: _____

- How is your health information at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any physical symptoms or health concerns _____
_____

- Are you having problems with your sleep? Yes _____ No _____ (please circle if applicable)

Sleeping too much Sleeping too little Poor quality of sleep Disturbing dreams Other

- Do you exercise? Yes_____ No ____ How often? _____
- Are you having difficulty with appetite or eating habits? Yes _____ No _____ (please circle if applicable)

Eating less Eating more Binging Restricting

- Do you use alcohol on a regular basis? Yes ___ No ____ If yes, how often?

Daily Weekly Monthly Rarely Never

- Do you engage in recreational drug use? Yes _____ No _____ If yes, how often?

Daily Weekly Monthly Rarely Never

- Have you had suicidal thoughts recently? (circle if applicable)

Frequently Sometimes Rarely Never

- Have you had any suicide attempt? If so, how long ago?
  _____

Symptoms (please circle what applies):

Depressed mood	Yes/ No
Extreme mood swings	Yes/ No
Anxiety	Yes/ No
Panic attacks	Yes/ No
Phobias	Yes/ No
Sleep disturbances	Yes/ No
Hallucinations	Yes/ No
Substance abuse	Yes/ No
Eating Disorder	Yes/ No
Body image problems	Yes/ No
Obsessive/circular thinking	Yes/ No
Getting easily irritable	Yes/ No
Co-dependency	Yes/ No

Withdrawal/lack of motivation Yes/No

Social Information

Are you currently in a romantic relationship? Yes____ No____ If yes, for how long? _____

On a scale from 1-10 how would you rate the quality of your current relationship (with ten being the best)? _____

Do you have any concerns about current or history of domestic violence? Yes____ No _____

In the last year, have you experienced any significant life changes or stressors?:_____

_____

_____

_____

Occupational Information

Are you currently employed? Yes ____ No ____

Occupation: _____

Please list any work-related stressors, if any:

_____

Other Information

What do you consider to be your strengths? _____

_____

What is/are your goal/s for therapy? _____

_____

_____

_____

_____

What has helped or not helped in past therapy (if applicable)?

_____

_____

_____