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Intake Form (one Page)

NAME: _____ MALE/FEMALE: _____DATE: _____

ADDRESS: _____

TELEPHONE: H: _____ W/OFF.: _____ D.O.B.: _____ Age: _____

HIGHEST GRADE/DEGREE: _____ REFERRAL BY:_____

PERSON AND TEL. NO. TO CALL IN EMERGENCY: _____

MARITAL STATUS: _____ FORMER/PRESENT MARRIAGE(S) (years): _____

SPOUSE NAME: _____ AGE: _____ OCCUPATION: _____

CHILDREN/STEP/GRAND (names/ages): _____

SIBLINGS (names/ages): _____

PARENTS/STEPPARENT(s) (Ages or year of death): _____

OCCUPATION/POSITION: _____

PRESENTING PROBLEM: _____

MEDICAL DOCTOR(S): _____ PHONE(S): _____ LAST EXAM: _____

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations, current medication): _____

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Therapist: _____ Dates: __ to __Phone: _____ Address: _____

Initial reason: _____ Process and outcome: _____

2. Therapist: _____Dates: __ to ___ Phone: _____ Address: _____

Initial reason: _____ Process and outcome: _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA, etc.):

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:

_____

Use the space on the back of this form if you need to give further information.