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TELEHEALTH only
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INTAKE FORM

TODAY'S DATE: _____FILE #: _____DX: _____

CLIENT NAME: _____ DOB: _____Parent Name (if minor): _____
Home Phone #: _____Work Phone #:_____Cell Phone #:_____
Preferred phone # is Home, Work, or Cell? Therapist can contact me at home or work and/or leave a message. YES NO
Address, city, state,zip:_____
Referred By: _____ May I say thank you for referring you to me? YES NO
Employer: _____ Job Title _____
Education: _____

FAMILY INFORMATION: Relationship Status (circle): SINGLE MARRIED DIVORCED LIVING TOGETHER
Partner/Significant other's name:_____
Number of years in relationship/married: _____ Previous Marriages/Divorces? _____
Dates of marriages and/or divorces_____
Children (Names and ages):

_____ _____
_____ _____
_____ _____
_____ _____

Describe your relationship with your children: _____
_____

FAMILY OF ORIGIN:
Father's Name: _____ Age: _____ Living? _____Where? _____
Marital Status: _____ Education: _____ Occupation: _____
Mother's Name: _____Age:_____ Living? _____ Where? _____
Marital Status: _____ Education: _____Occupation: _____
Describe relationship with your parents: _____
_____
_____

List Siblings (Oldest to youngest and **include yourself**):
Name: _____ Age: _____Living? _____ Where?: _____ Occupation: _____
Name: _____ Age: _____Living? _____ Where?: _____ Occupation: _____
Name: _____ Age: _____Living? _____ Where?: _____ Occupation: _____
Name: _____ Age: _____Living? _____ Where?: _____ Occupation: _____
Name: _____ Age: _____Living? _____ Where?: _____ Occupation: _____
Name: _____ Age: _____Living? _____ Where?: _____ Occupation: _____
Name: _____ Age: _____ Living? _____Where?: _____ Occupation:_____
Describe relationships with siblings: _____
_____
Has anyone in your family had a serious mental health problem? _____
_____

(Complete side two)

CHEMICAL USE:
Do you use: Alcohol _____ Tobacco _____ Caffeine _____

Do you think you have a current problem with drugs/alcohol, etc.? YES: _____ NO: _____ MAYBE: _____
Have you ever felt that you ought to Cut down on your drinking or drug use? YES___ NO___
Have people Annoyed you by criticizing your drinking or drug use? YES___NO___
Have you ever felt bad or Guilty about your drinking or drug usage? YES___ NO ___
Have you ever had a to drink or use drugs/alcohol first thing in the morning (Eye-opener) to steady your nerves or get rid of a hangover or just get the day started? YES___ NO___
What medications are you currently using? _____

CURRENT HEALTH:
Describe your general health: _____
Describe concerns and/or changes in:
Sleeping: _____
Work Life: _____
Hobbies/Play: _____
Relationships: _____
Financial: _____
Spiritual: _____
Physical Health: _____
Sexuality: _____
Anything else: _____
What do you like about yourself? _____
What do you do for fun? _____

CURRENT CONCERNS AND/OR PROBLEMS CHECKLIST:

_____Relationship with parents	_____Childhood abuse	_____Grief	_____Death
_____Relationship with children	_____Emotional abuse	_____Alcohol/chemical use	_____Suicidal feelings
_____Relationship with friends	_____Verbal abuse	_____Compulsiveness	_____Loneliness
_____Relationship with partner/ Significant other	_____Sexual abuse	_____Overeating	_____Employment
	_____Sexual acting out	_____Rapid weight changes	_____Finances
_____Relationship with Co-workers/boss	_____ Sexuality	_____Eating disorders	_____Overworking
	_____Sexual orientation	_____Anxiety	_____Career/job
_____Codependency	_____Sexual identity	_____Depression	_____Pregnancy/having children
_____Personal growth	_____Spiritual/religious	_____Phobias (list):_____	

_____Other issues: _____

PREVIOUS COUNSELING:
Have you ever had counseling? _____Date of counseling: _____Agency/counselor: _____
Problem treated: _____
Did you like your experience in counseling? _____
Was counseling successful? _____
What is your current reason for seeking therapy? _____
How long have you been experiencing this problem? _____
What have you tried so far that has helped? _____
What have you tried that has not helped? _____

Is there anything else you would like to add that may be helpful? _____

Client signature:

Signature: _____ **Date:** _____

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