Intake Form

Please fill out as completely as possible and bring with you to our first session. If you wish, you can either email it back to me: amendozamccoy@yahoo.com or you can bring it with you to our first session. If you do no desire to answer any question, just leave it blank.

TODAY'S DATE: _____

NAME: _____ DOB: ____/_____/____ AGE: _____

ADDRESS: _____ CITY: _____ ZIP:_____

BEST PHONE: _____ BEST EMAIL: _____

PERSON & PHONE # TO CALL IN CASE OF AN EMERGENCY:_____

PLEASE ANSWER EACH QUESTION:

REFERRAL SOURCE:_____

HIGHEST GRADE/ DEGREE:_____

OCCUPATION:_____ HOW LONG?_____

DO YOU ENJOY YOUR WORK?_____PRESENTING PROBLEM: (What are your main worries or fears? When did it start? How does it affect you?)

_____

_____

_____

ESTIMATE THE SEVERITY OF THE PROBLEM: MILD MODERATE SEVERE

Mental Status Exam:

CURRENT RELATIONSHIP STATUS:_____ ARE YOU MARRIED? YES NO HOW LONG?:

WERE YOU PREVIOUSLY MARRIED? YES NO PARTNER OCCUPATION:_____

HOW HAPPY ARE YOU IN YOUR CURRENT RELATIONSHIP? (MARRIED OR NOT) N/A

1 VERY UNHAPPY 2 3 4 5 VERY HAPPY

FAMILY INFORMATION:

DO YOU HAVE CHILDREN/STEP/ GRAND? (GIVE NAMES AND AGES)

(1) _____ (2)_____ (3)_____

(4)_____ (5)_____ (6)_____

PARENTS (GIVE NAMES, AGES, IF DECEASED, & BRIEF STATEMENT ABOUT THE RELATIONSHIP)

MOTHER:_____

FATHER:_____

STEPPARENTS:_____

IF PARENTS DIVORCED: GIVE YOUR AGE AT THE TIME:_____ DESCRIBE HOW IT EFFECTED YOU:

_____

_____

SIBLINGS: (GIVE NAMES, AGES, OCCUPATION, IF DECEASED)

1._____ 2._____ 3._____

4._____ 5._____ 6._____

DESCRIBE YOUR CHILDHOOD IN GENERAL:_____

_____

_____

FAMILY HISTORY OF ALCOHOLISM/ADDICTIONS, MENTAL ILLNESS, OR VIOLENCE?:_____

_____

HAVE YOU HAD PAST COUNSELING? (Psychiatric history) YES NO WHEN? _____
(SPECIFY NAME(S), REASON FOR THERAPY, #OF SESSIONS, AND HOW IT ENDED):_____

DO YOU HAVE HEALTH ISSUES? : YES NO EXPLAIN _____

YOUR PRIMARY PHYSICIAN: _____ PHONE: _____
CURRENT MEDICATIONS:
1) _____ 3) _____
2) _____ 4) _____
RISK FACTORS:
ANY EXPERIENCE FEELING SUICIDAL, PLANS/ATTEMPTS/OR SELF INJURIOUS BEHAVIOR?:_____

PLEASE DESCRIBE YOUR ALCOHOL USE/ ILLICIT DRUG USE PAST OR PRESENT:

ARE INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S?, LAWSUITS, DIVORCE, OR CUSTODY DISPUTES? (IF YES, Please Explain)

YOUR CURRENT COUNSELING GOALS: (What are you hoping to get out of this experience?)

Psychosocial Information:
WHAT DO YOU DO FOR FUN? (What gives you pleasure and joy in life?)

FRIENDSHIPS, COMMUNITY, &SPIRITUALITY (Describe the quality, frequency, and type of connections your have?)

Working Diagnosis _____

INSURANCE INFO:
INSURANCE COMPANY: _____ INSURANCE PH #_____
INSURED NAME: _____ ____ D.O.B: _____
INSURED ID #: _____ GROUP #: _____ SS#: _____
CLIENT'S NAME: _____ D.O.B: _____
YOUR HEALTH INSURANCE MAY OR MAY NOT COVER YOUR COUNSELING SERVICES. BE SURE TO ASK IF YOUR THERAPIST IS AN IN NETWORK PROVIDER.