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Confidential Intake Form

Date: _____ Fee: _____

Patient Full Name: _____ □ Female □ Male

Date of Birth: _____ Age: _____

Home Address: _____

Phone Numbers: Home:_____ Cell: _____

School Name, grade, and teacher: _____

Child Study Team Evaluation: Y/N Special Education Classification_____ Date: _____

Bio. Mother's name: _____ DOB: _____ Age: _____

Home address (if different from above): _____

Phone numbers: Home: _____ Cell: _____

Work: _____ Other: _____

Occupation: _____ Employer name and address: _____

Bio. Father's name: _____ DOB: _____ Age: _____

Home address (if different from above):_____

Phone numbers: Home: _____ Cell: _____

Work: _____ Other: _____

Occupation: _____ Employer name and address: _____

*If biological parents are not married to each other, date of separation/divorce: (If applicable):_____

Custody: Joint _____ Other: _____ (REQUEST COPY of DIVORCE DECREE)

Step-parent name: _____ DOB: _____ Age: _____

Home address: _____

Phone numbers: Home: _____ Cell: _____

Work: _____ Other: _____

Step-parent name: _____ DOB: _____ Age: _____

Home address: _____

Phone numbers: Home: _____ Cell: _____

Work: _____ Other: _____

Patient's children/siblings: (after name, note if step-child, step-sibling, or half sibling)

Names: _____ DOB: _____ Age: _____

Names: _____ DOB: _____ Age: _____

Names: _____ DOB: _____ Age: _____

Names: _____ DOB: _____ Age: _____

Referral Source: _____

Services Requested: ☐ Counseling/Psychotherapy ☐Family Therapy ☐ Marital/Couples Counseling

☐ Other specify: _____

Primary concern/issues/chief complaint/reason for seeking treatment:

_____

_____

_____

_____

_____

_____

Mental Health History

History of Symptoms (when did these symptom/problems first appear and how persistent have they been?)

_____

_____

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_____

Eating/Sleeping Patterns: _____

Previous Counseling? (name of provider, dates and duration of treatment):

_____

_____

_____

Referred for counseling in the past? _____

Recent or past significant stressors/losses (e.g., moves/relocation, divorce, accidents, illnesses, deaths, abuse/neglect, domestic violence) : _____

_____

_____

_____

Hospitalizations (medical, psychiatric): _____

_____

Any serious symptom (e.g., hallucination, suicidal and/or homicidal ideation, etc.): _____

_____

Family history of emotional difficulties/mental illness: _____

_____

_____

History of alcohol and/or substance abuse: _____

Any substance abuse treatment received: _____

History of substance use by family members? _____

Family of Origin and Current Family

Note current living arrangement, support systems, relationships, and family/childhood history:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Current Medications: _____

Primary Care Physician: _____

Psychotherapist Name: _____ Signature: _____ Date: _____