Center for Family & Maternal Wellness
freedom. Growth. Development. Healing.

Individual Therapy Intake Form

Client's Name: _____ _____ _____ Preferred: _____
LAST FIRST MI

Admission Date: _____ DOB: _____ County: _____

SSN#: _____ -____ -_____ Gender: _____ Race/Ethnicity: _____

Age: _____ Height: _____ Weight_____

Address: _____
Street City State Zip

Home phone: _____ Work Phone: _____ Cell Phone: _____
Leave Message? ☐Yes ☐No Leave Message? ☐Yes ☐No Leave Message? ☐Yes ☐No

Email Address: _____ Occupation: _____

Employer/School: _____ Relationship Status: _____

Number of years (or highest level of) education: _____

Other services currently receiving: _____

Name/Address of financially responsible party if other than client (*For minors or anyone using 3rd part, non-insurance payor.)*

If client is a minor, name/address/phone of custodial parent, if different from name above:

Legal Guardian ☐N/A _____ _____
Relationship to Client

Address: ☐ Same as above _____

Telephone: _____Home _____ Cell _____ Work

Annual Household Income (please include all sources for consideration): _____
Family and household members (includes housemates, spouse, partner, and all children *(Continue on back if needed.)*

Name	Age	Gender	Relationship	Living With you?
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No

Religion _____ Place of worship _____

Is it important for you to have spirituality included in your therapy? ☐Yes ☐No

Physician's Name: _____ Phone: _____ Last physical examination: _____

Physician's Address: _____

It is our practice to coordinate care with the client's physician when this would be helpful to treatment. If you agree that we may contact your physician, please check here: ☐ *(Please sign a release of information with your therapist for this purpose*.)

List any surgeries or illnesses you have had the past five years _____

_____

Current Medications/Dosage (include those taken within the last 3 months)

1. _____ _____ 3. _____ _____

2. _____ _____ 4. _____ _____

Medical concerns:

_____

_____

Known allergies: _____

What is the purpose for your visit to Center for Family & Maternal Wellness at this time? _____

_____

Have your received counseling/therapy previously? ☐Yes ☐No If yes, when? _____

Name of Previous Therapist(s) _____ Previous concerns addressed: _____

Previous Diagnoses

_____ _____ _____

Are you a returning client? ☐Yes ☐No How did you learn about CFM Wellness? _____

Were you referred to CFM Wellness? ☐Yes ☐No Please indicate referral source: _____

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor. Place a check in the box that best describes the frequency of your symptoms. (N=Never, S=Sometimes, O=Often, A=Always)

I AM EXPERIENCING...	N	S	O	A	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING...	N	S	O	A	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE...	N	S	O	A	For how long?
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE...	N	S	O	A	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE...	N	S	O	A	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
Thoughts about harming my children					

MY EATING INVOLVES...	N	S	O	A	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					

I USE THE FOLLOWING....	N	S	O	A	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
Prescription pain pills					
Synthetic drugs (ecstasy, weed, etc.)					

I HAVE...	N	S	O	A	For how long?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
Questions about my gender expression					
Concern for my safety at home					
Concern for my safety outside					

EMPLOYMENT & SELF-CARE	N	S	O	A	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					
I don't have reliable transportation					

PERSONAL AND FAMILY HISTORY

1. Have you ever been hospitalized for a psychiatric illness? ☐ Yes ☐ No
   Please explain:

2. Has a close relative ever been hospitalized for a psychiatric illness? ☐ Yes ☐ No
   Please provide reason, dates, duration stay:

3. Does anyone in your family have a mental illness? ☐ Yes ☐ No
   If yes, who?

4. Has anyone in your family every attempted or committed suicide? ☐ Yes ☐ No
   If yes, who?

5. Does anyone in your family have a substance abuse problem? ☐ Yes ☐ No
   If yes, who?

6. Have you ever been arrested? ☐ Yes ☐ No
   Please explain:

7. How well you are doing on your job?

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not working	Cannot Function		Mild Problems		Moderate Problems		Serious Problems		No Problems

8. How well you are doing in your marital/significant other relationship?

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not working	Cannot Function		Mild Problems		Moderate Problems		Serious Problems		No Problems

9. How well you are doing in your family relationships?

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not working	Cannot Function		Mild Problems		Moderate Problems		Serious Problems		No Problems

10. How well you are doing in relationships with people outside your family?

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not working	Cannot Function		Mild Problems		Moderate Problems		Serious Problems		No Problems

11. Please rate your current physical health:

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor									Excellent

12. Please rate your general happiness and well-being:

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐

Very Poor Excellent

Are there any other concerns that you'd like us to help with not indicated above? Please list:

_____

_____

_____

_____

_____

_____

FOR THERAPIST'S USE

Therapist: _____ **Office:** _____ **Fee (90791):** _____ Fee: **(98034/47)**_____ **Date:** _____

Payment: ☐ Ins* ☐ EAP ☐ 3rd Party Non-Insurance Guarantor (i.e., church) ☐Self-pay ☐Sliding scale (pre approval required_

*Insurance Information form must be completed, signed by client, stapled to photocopy of medical card, and included with intake paperwork.
☐ Check if insurance paperwork and/or photocopy of medical card is NOT included and will be submitted later.

File: ☐Individual ☐Marital/Couple ☐Family (Number of members _____) ☐Group ☐Maternal MH

If Couple or Family, check one: ☐**Primary client** (for insurance purposes; contact for scheduling) ☐ **Additional client(s)**