Lisa Hayes, M.S., Licensed Marriage & Family Therapist, MFC #48886
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CLIENT INTAKE FORM

Please provide the following information and answer the questions below. Please note that information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____Age: _____Gender: □ Male □ Female □ Transgender □ Intersex

SSN: _____ CA Driver's License or ID Card #: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/dates of birth: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No
Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

Emergency Contact / Relationship/Phone Numbers: _____

_____

Referred by (if any): _____

Have you previously received any type of outpatient mental health services (psychotherapy, psychiatric services, etc.)?

□ No
□ Yes, previous therapist/practitioner: _____

Have you previously received any type of inpatient mental health services?
□ No
□ Yes, List date and location of hospitalization: _____

Have you ever attempted suicide?
□ No
□ Yes, List date and treatment received: _____

Are you currently taking any prescription medication?
□ Yes □ No

Please list medication(s) and dosage: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes □ No

Please list medications: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any chronic or current specific health problems you are experiencing:

_____

_____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No □ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No □ Yes

If yes, please describe: _____

8. How much alcohol do you consume per week? _____

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, sibling, child, uncle, etc.).

	Please Circle	Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Aspergers Syndrome	yes/no	
Attention Deficit Disorder	yes/no	
Autism	yes/no	
Bi-polar Disorder	yes/no	
Dementia	yes/no	
Depression	yes/no	
Developmental Disorders	yes/no	
Domestic Abuse	yes/no	
Eating Disorders	yes/no	
Learning Disabilities	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Panic Attacks	yes/no	
Posttraumatic Stress Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other _____		

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Current Insurance Plan and ID #:_____

3. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

_____

4. What do you consider to be some of your strengths?

_____

_____

_____

5. What do you consider to be some of your weaknesses?

_____

_____

6. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

_____

_____

Please sign and date below to confirm that the information you've provided is true and correct:

_____

Client Name or Parent if a minor Date