INTAKE FORM: ADULT INDIVIDUAL

Name:_____Birth Date:_____
Address:_____
City: _____ Zip Code: _____
Cell Phone: _____
Other Phone (work, home): _____
May I leave a message?_____
E-mail Address: _____
In case of emergency, contact: (name)_____
Address:_____
Phone Number:_____
Relationship:_____

Relationship & Family Information:

Married_____ Domestic Partnership_____ Committed relationship_____
Single_____Separated/Divorced_____ Widowed_____
Other (describe)_____
Length of current relationship: _____
Describe the quality of this relationship:
Poor____ Fair____ Good_____ Excellent_____
Please list children (any age):_____
Please list members of your household: _____
_____

Mental Health Services & History

Have you received any kind of mental health services before? If yes, describe:
Type_____
Clinician/Agency_____
Dates:_____
Have you ever experienced any of the following:
Depression_____ Anxiety_____
Panic Attacks_____
Eating Disorders_____ Trauma/Abuse_____
Substance abuse/dependency_____ Domestic violence_____
Insomnia_____

Suicidal thoughts/attempts_____
Please explain any conditions checked above_____

_____

_____

General Health
Medical diagnoses or conditions:

_____

Medications:_____
Describe your current physical health:
Poor_____ Fair_____ Good_____ Excellent_____
How many alcoholic beverages per week? _____What kind of alcohol?_____ Do you engage in recreational drug use?_____ If yes, what drug(s) ?_____

Employment/Education
Highest level of education:_____
Profession & Current employer:_____
Describe your professional life:
Unsatisfying____ Somewhat satisfying_____ Satisfying_____ Very satisfying_____

Reasons for seeking treatment

Please describe current challenges, stressors and reason for seeking therapy:

_____

_____

_____

Please describe your goals and desired outcome for therapy:

_____

_____

Who referred you/ how did you find me:

Date completed:_____

Carla Savage-Sachs, M.A., MFT/ 2231 Bayview Heights Dr, Los Osos, CA 93402/ 805-235-6314