MARITA BETH EARLE, M.A., L.M.F.T.

CLIENT INTAKE FORM

Name: _____ Date: _____

Address: _____

County: _____

Phone: (h) _____ (c) _____ (w) _____

Email Address: _____

Age: _____ Date of Birth: _____ Religious Affiliation: _____

Male: Female: Race / Ethnicity: _____

Person to contact in case of emergency: _____ Relationship: _____

Address: _____ Phone numbers: _____

Marital Status: (check one)

☐ Single ☐ Married (# of years____) ☐ Separated ☐ Divorced (how long? ____) ☐ Other

☐ Remarried (# of years____) ☐ Widowed (how long___) ☐ Co-Habitating (living together how long? _____)

If never married, check box and skip this section:

MARITAL HISTORY:

1st marriage: Beginning Date: _____ Ending Date: _____ Spouse: _____Years married?_____

Children and Ages: _____

_____

2nd marriage: Beginning Date: _____ Ending Date: _____ Spouse: _____ Years married?_____

Children and Ages: _____

_____

3rd marriage: Beginning Date: _____ Ending Date: _____ Spouse: _____ Years married?_____

Children and Ages: _____

_____

4th marriage: Beginning Date: _____ Ending Date: _____ Spouse: _____ Years married?_____

Children and Ages: _____

_____

List the names and ages of all people currently living in your home:

Name	Age	Relationship	Occupation

Name	Age	Relationship	Occupation

Who has custody of the minor children living in your home? _____

Highest Level of Education: (check one)

☐Grade School ☐Middle School ☐High School ☐Some College ☐Bachelor's Degree ☐Master's Degree ☐Doctorate

Determined Fee (leave blank: office use only): _____

Who suggested you contact us? _____

Are you currently in therapy elsewhere? ☐Yes ☐No

If so, where / with whom? _____

Have you ever consulted a professional counselor before? ☐Yes ☐No

If yes: Name of counselor or agency: _____

MEDICAL HISTORY:

Primary Care Physician: _____ Psychiatrist: _____

Current Medical Conditions: _____

_____

History of Medical Conditions: _____

_____

Have you ever been hospitalized for an emotional or psychological problem? ☐Yes ☐No

If yes, Dates: _____

Hospital(s): _____

Reason(s): _____

DATE OF LAST PHYSICAL EXAM: _____

Current Medications:

Medication	Dosage	Prescribed By	Date Prescribed

Compliant? ☐Yes ☐No Complaints? ☐Yes ☐No

Have you ever considered suicide? ☐Yes ☐No

Have you ever attempted suicide? ☐ Yes ☐ No

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Your Medical History:

☐ Headaches	☐ Miscarriage	☐ Impaired hearing / vision
☐ Seizures	☐ Abortion	☐ Chest pain
☐ Alcohol use / abuse	☐ Dizzy spells	☐ Hypertension
☐ Weight gain	☐ Fainting	☐ Shortness of breath
☐ Weight loss	☐ Blackouts	☐ Nausea or abdominal distress
☐ Compulsive dieting	☐ Numbness	☐ Muscle spasms
☐ Vomiting / use of laxatives	☐ Back pain	☐ Tremors
☐ Pregnancies	☐ Drug use / abuse	☐ Sexual difficulties

Please check if any of these are or have been present in your extended family or your spouse's family:

	Your Family	How Related?	Your Spouse's Family	How Related?
1. Depression	☐	_____	☐	_____
2. Anxiety	☐	_____	☐	_____
3. Mood swings	☐	_____	☐	_____
4. Schizophrenia	☐	_____	☐	_____
5. Suicide or attempts	☐	_____	☐	_____
6. Alcohol use / abuse	☐	_____	☐	_____
7. Drug use / abuse	☐	_____	☐	_____
8. Emotional illness	☐	_____	☐	_____
9. Electric Shock Therapy	☐	_____	☐	_____
10. Other _____	☐	_____	☐	_____

YOUR EMPLOYMENT HISTORY:

_____

_____

YOUR LEGAL HISTORY: (i.e. criminal violations; court appearances; custody hearings; civil suits, etc.)

_____

_____

Is your family or anyone in your family currently involved with the following agencies? If yes, please explain

Department of Human Services: ☐ Yes ☐ No

Probation or Parole: ☐ Yes ☐ No

Attorney: _____

Other (please specify): _____

For what areas of your life are you seeking assistance? (i.e., marital, family, school, work, substance abuse, grief)

Area 1: _____

Area 2: _____

Area 3: _____

For each area you identified, what changes/improvements will be signs of progress?

Area 1: _____

Area 2: _____

Area 3: _____

What do you hope to accomplish today? _____

_____

_____

Please check any of the following that are presently causing you difficulty:

- ☐ Depressed mood
- ☐ Lost interest in most activities
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Difficulty going to sleep
- ☐ Difficulty staying asleep
- ☐ Fatigue, loss of energy
- ☐ Feelings of worthlessness
- ☐ Inappropriate guilt
- ☐ Difficulty concentrating
- ☐ Preoccupation with death
- ☐ Suicidal thoughts
- ☐ Excessive, uncontrollable worry
- ☐ Friends
- ☐ In-laws
- ☐ Dating
- ☐ Trust
- ☐ Decision-making
- ☐ Finances
- ☐ Recurring, intrusive, traumatic memories
- ☐ Decreased need for sleep
- ☐ Increased talking
- ☐ Racing thoughts
- ☐ Distractible
- ☐ Elevated mood, feel "up"
- ☐ Engaging in risky behaviors
- ☐ Mood swings
- ☐ Feelings of Panic
- ☐ Difficulty organizing my thoughts
- ☐ Sexual problems
- ☐ Loneliness
- ☐ Parents
- ☐ School
- ☐ Career choices
- ☐ Unhappiness
- ☐ Self-concept
- ☐ Education
- ☐ Food
- ☐ Careless, forgetful, lose things, easily distracted
- ☐ Fear of losing control
- ☐ Fear of dying
- ☐ Flashbacks
- ☐ Efforts to avoid memories
- ☐ Fear of social situations
- ☐ Impulsive
- ☐ Angry
- ☐ Easily upset, on edge
- ☐ Marital problems
- ☐ Overwhelmed
- ☐ Restlessness
- ☐ Irritable
- ☐ Relaxation
- ☐ Confusion
- ☐ Legal matters
- ☐ Pre-marital
- ☐ Religion
- ☐ Stress
- ☐ My past
- ☐ Recurring, undesirable thoughts
- ☐ Assertiveness
- ☐ Parenting
- ☐ Nightmares
- ☐ Bed-wetting
- ☐ Nervousness
- ☐ Children
- ☐ Divorce
- ☐ Temper
- ☐ Inferiority
- ☐ Drug use / abuse
- ☐ Work
- ☐ Guilt
- ☐ Alcohol use / abuse
- ☐ Sadness
- ☐ Shyness
- ☐ Abuse
- ☐ Separation
- ☐ Memory
- ☐ Relationships
- ☐ Repetitive behaviors (checking, hand washing) or Mental acts (counting, repeating words silently) that you feel driven to perform

Now identify the **TWO** items from the previous list that are causing you the **most** difficulty.

1. _____ 2. _____

History of alcohol use: (describe) _____

History of drug use: _____

Current alcohol use: _____

Current drug use: _____

Tobacco use (describe) _____

Any past or current alcohol or drug use / abuse by a family member, describe:

_____

_____

Please provide any additional information that you think may be useful to your therapist:

_____

_____

_____

Thank you for taking the time to provide this most valuable information.