Althea Lee, M.S.

Licensed Marriage and Family Therapist
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CLIENT INTAKE (EAP)

Please provide the following information and answer ALL the questions below. Please note: All of information that you provide is protected as confidential information.

Date: _____

Last Name: _____ **First Name** _____ **MI** ____

Other Names Used: _____

Address: _____

City _____ **State** _____ **Zip** _____

GENDER: ☐ Male ☐ Female **AGE:** _____ **D.O.B:** _____ **SSN:** _____

E-mail: _____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Phone: (Home) (Cell) (Work)

_____ _____ _____

May we leave a message? ☐ Yes ☐ No

Communication Preferences for appointment reminder? ☐ Email ☐ Text ☐ Both ☐ None

RACE AND ETHNICITY: (Mark all that apply)

☐ White ☐ African American ☐ Hispanic/Latino Ethnicity ☐ Asian ☐ Filipino

☐ Pacific Islander ☐ Native American ☐ American Indian ☐ Middle Eastern

☐ Other: _____

REASON FOR VISIT:

Referred by (if any): _____

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

Hobbies/Activities:

EAP Name: _____

Authorization or ID Number# _____

Insured Persons Name:

Name: _____ **D.O.B:**_____ **Your Relationship:** _____

Address if different: _____

Phone Number: _____

LIVING ARRANGEMENT:

☐ Rent ☐ Own ☐ Roommate ☐ Homeless ☐ Halfway house ☐ Shelter ☐ Group home
☐ Mother ☐ Father ☐ Father & Mother ☐ Other: _____

FAMILY HISTORY:

Children? ☐ Yes ☐ No How many? _____ Live with children ☐ Yes ☐ No

Name: **Gender** **Age**

_____

_____

_____

Mother's Name **Father's Name**

_____ _____

Relationship with Mother

☐ Close ☐ Good ☐ Fair ☐ Poor ☐ Distant

☐ Other _____

Relationship with Father

☐ Close ☐ Good ☐ Fair ☐ Poor ☐ Distant

☐ Other _____

Siblings? ☐ Yes ☐ No How many sisters _____ How many brothers _____

Name	**Gender**	**Age**	**Relationship with sibling**
			☐ Close ☐ Good ☐ Fair ☐ Poor ☐ Distant
			☐ Close ☐ Good ☐Fair ☐ Poor ☐ Distant
			☐ Close ☐ Good ☐ Fair ☐ Poor ☐ Distant

Have you ever ran away from home? ☐ Yes ☐ No How many times?____ Date of last time _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

How would you rate your current eating habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

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

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Are you currently experiencing overwhelming? (If yes, for approximately how long)?

☐ Sadness _____ ☐ Grief _____ ☐ Depression _____ ☐ Anger _____

Are you currently experiencing any of the following?

☐ Anxiety ☐ Panic attacks ☐ Phobias

_____

If yes, when did you begin experiencing this?

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

IF YES, Name of previous Therapist/Practitioner: _____

Last date of appointment: _____

How long where you in therapy? ☐ Months _____ ☐ Years _____ ☐ Weeks ____ ☐ Days _____

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

List Medications/Dosage:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you currently taking any psychiatric medication? ☐ Yes ☐ No

List Medications/Dosage:

_____ _____ _____

_____ _____ _____

Have you ever been hospitalized? ☐ Yes ☐ No
Reason for Hospitalization:

If yes, date of last hospitalization: _____ Number of times hospitalized: _____

Have you ever attempted suicide? ☐ **Yes** ☐ **No** **(If yes, how many times)** _____

When? _____

If yes, do you feel that way now? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No (If yes how many times a week?) _____

Do you use drugs? (Marijuana etc.) ☐ Yes ☐ No (If yes how many times a week?) _____

Do you misuse prescription medication? ☐ Yes ☐ No (If yes how many times a week?) _____

Are you addicted to Alcohol or Drugs? ☐ Yes ☐ No ☐ Alcohol ☐ Drugs

DRUGS & ALCOHOL:

Drug of Choice: _____ _____ _____

Amount: _____ _____ _____

Frequency: _____ _____ _____

Duration: _____ _____ _____

Do you attend AA or NA? ☐ Yes ☐ No (if yes which one) _____ Frequency _____

Do you have a sponsor? ☐ Yes ☐ No

Do you have a Support Groups? ☐ Yes ☐ No (What kind) _____

Do you have any problems with the following?

☐ HIV/Aids ☐ High Blood Pressure ☐ Diabetic ☐ Seizures ☐ Asthma ☐ Allergies

☐ Cancer ☐ Heart problems ☐ Polo ☐ Cerebral Palsy ☐ Hepatitis ☐ Headache

☐ Nightmares ☐ Sweats ☐ Problems with Weight ☐ Panic attack ☐ Shortness of breath

☐ Hear voices ☐ Have visions

☐**Other:**

FEMALES ONLY:
Are you pregnant? ☐ Yes ☐ No Due Date? _____

Have you had any Abortions? ☐ Yes ☐ No
(Number of terminations) _____ Date of last termination _____

Skin conditions? ☐ Yes ☐ No

List what kind: _____

WORK HISTORY:

Are you currently employed? ☐ Yes ☐ No (If no please put source of income) _____

Length of employment: _____

Place of Employment:	**Job title:**	**Monthly Income**
_____	_____	$ _____

Source of Income: _____ $ _____

Monthly Household income: $ _____

Do you enjoy your work? ☐ Yes ☐ No If no Explain

Is this visit work related? ☐ Yes ☐ No If yes explain

Is there anything stressful about your current work? (Please list)

Religious Belief: _____

LEGAL ISSUES: ☐ Yes ☐ No **(IF YES PLEASE EXPLAIN)**

FAMILY HISTORY:

Family History of Mental Illness:

☐ Spouse ☐ Children ☐ Mother ☐ Father ☐ Siblings ☐ Grandmother
☐ Grandfather ☐ Aunt ☐ Uncle ☐ Other _____

If any checked above, describe illness (give diagnosis if known):

Alcohol or Drug addiction ☐ Yes ☐ No **(Please indicate whom in your family)**

_____ ☐ Alcohol ☐ Drugs _____ ☐ Alcohol ☐ Drugs

_____ ☐ Alcohol ☐ Drugs _____ ☐ Alcohol ☐ Drugs

_____ ☐ Alcohol ☐ Drugs _____ ☐ Alcohol ☐ Drugs

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

SUPPORT SYSTEMS:

_____ _____

Client or Guardian's Signature *Date*

IN CASE OF EMERGENCY CONTACT:

Person to contact:
Name:

_____

Address:

_____

City **State** **Zip**

_____ _____ _____

Phone **Relationship**

_____ _____

I _____ give permission for **Althea Lee, LMFT** (Therapist) to contact the above person in the event of an emergency:

_____ _____

Client's Signature *Date*