Althea Lee, M.S.

Licensed Marriage and Family Therapist
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CLIENT INTAKE

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:

Name/Type of Insurance: ____________________

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**

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*