



# Intake Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Spouse/Partner's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Primary Phone number : \_\_\_\_\_  Cell  Home OK to leave msg?  Yes  No

Email address \_\_\_\_\_ OK for paperwork and/or correspondence?  Yes  No

Insurance Carrier \_\_\_\_\_ Insured's name \_\_\_\_\_ DOB: \_\_\_\_\_

1. Sex  Male  Female

2. Marital/Relationship Status

- Single (never married)
- Significant Other
- Cohabiting (living together)
- First Marriage
- Separated
- Divorced
- Widowed
- Remarried (after divorce)
- Remarried (after spouse's death)

3. Current Employment

- Full-time
- Part-time
- Homemaker
- Unemployed
- Full-time student
- Part-time student
- Retired

4. Education

- grade school/junior high
- attending/attended high school
- High school graduate
- Attending/attended college
- College graduate
- Attending/attended graduate school
- Technical school degree
- Graduate degree (Masters)
- Graduate degree (Doctoral)

5. Children (include biological, adopted, foster, step, etc)

Name	Sex	Age	Type (bio,step,etc.)	Custody?
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Race/Ethnicity

- Caucasian  Native American  Latin or Spanish  Asian  African American  Multiracial  Other \_\_\_\_\_

7. Language spoke in the home other than English \_\_\_\_\_

8. Primary Care Info: (Name and Phone #) \_\_\_\_\_

If Currently under physician's care please indicate what for (and Physician's or Psychiatrist's name if different than PCP)

\_\_\_\_\_

List current medications and amounts \_\_\_\_\_

\_\_\_\_\_

Do you want us to coordinate care with your physician?  Yes  No

## Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- |  |   |
|--|---|
| <input type="checkbox"/> Depression or Anxiety<br><input type="checkbox"/> Alcohol or other drug abuse<br><input type="checkbox"/> Marital Problems<br><input type="checkbox"/> Communication Difficulties<br><input type="checkbox"/> Improved Sexual Relations<br><input type="checkbox"/> Sexual Orientation Questions<br><input type="checkbox"/> Child Adjustment/Parent Conflict<br><input type="checkbox"/> Thinking of harming self or others<br><input type="checkbox"/> Abuse (physical/verbal/sexual)<br><input type="checkbox"/> Difficulty with loss or death<br><input type="checkbox"/> _____ | <input type="checkbox"/> Blended Family Adjustment<br><input type="checkbox"/> Divorce<br><input type="checkbox"/> Life/Medical Stressors<br><input type="checkbox"/> Family Counseling<br><input type="checkbox"/> Relationship Enhancement<br><input type="checkbox"/> Adoption<br><input type="checkbox"/> Individual Counseling/Self growth<br><input type="checkbox"/> Pre-marital Counseling<br><input type="checkbox"/> School/Work adjustment problems<br><input type="checkbox"/> Weight/Body Image/Eating behaviors<br><input type="checkbox"/> _____ |
|--|---|

What event happened which made you think "I am (we are) calling a therapist?" \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please explain what you are hoping to achieve through the use of counseling services:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What behaviors would you like to change? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How would you know if things were getting better? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Specific Goals identified after first session (to be completed with therapist)    Plan Review Date: 6 months from intake

Child                     
  Family                     
  Couple                     
  Individual (with or without collaterals)

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_



Arrowhead  
Family  
Systems, LLC

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_  
Dawn Farmer, MFT Intern

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_  
Dr. Kimberly Bailey, DBH, LMFT - 10200

Have you received prior counseling? Y or N related to these problems? \_\_\_\_\_ Other \_\_\_\_\_

**If yes and related**, was it: Outpatient Inpatient (hospitalization)

When: \_\_\_\_\_ Where: \_\_\_\_\_

Counselor/Doctor: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_

Problem(s) treated: \_\_\_\_\_

Outcome:  Very Successful  Somewhat Successful  Stayed the Same  Somewhat Worse  Much Worse

**If Other**, was it: Outpatient Inpatient (hospitalization)

When: \_\_\_\_\_ Where: \_\_\_\_\_

Counselor/Doctor: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_

Problem(s) treated: \_\_\_\_\_

Outcome:  Very Successful  Somewhat Successful  Stayed the Same  Somewhat Worse  Much Worse

Any health issues that you are managing (including sleep, eating habits, drug or alcohol use) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family History of mental illness? (if yes, please describe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person to contact in case of an emergency (*limited information will be given, enough to get you the care you may need at that time*):

Name \_\_\_\_\_ Relationship \_\_\_\_\_



Phone \_\_\_\_\_