Arrowhead Family Systems, LLC

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
   - □ Cohabitating (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?
_____	_____	_____	_____	□ Yes □ No
_____	_____	_____	_____	□ Yes □ No
_____	_____	_____	_____	□ Yes □ No
_____	_____	_____	_____	□ Yes □ 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:

- □ Depression or Anxiety
- □ Alcohol or other drug abuse
- □ Marital Problems
- □ Communication Difficulties
- □ Improved Sexual Relations
- □ Sexual Orientation Questions
- □ Child Adjustment/Parent Conflict
- □ Thinking of harming self or others
- □ Abuse (physical/verbal/sexual)
- □ Difficulty with loss or death
- □ _____

- □ Blended Family Adjustment
- □ Divorce
- □ Life/Medical Stressors
- □ Family Counseling
- □ Relationship Enhancement
- □ Adoption
- □ Individual Counseling/Self growth
- □ Premarital Counseling
- □ School/Work adjustment problems
- □ Weight/Body Image/Eating behaviors
- □ _____

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 _____

Therapist Signature_____ Date _____

Gabby Cavale, MAS, LAMFT

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 _____