



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

Patient Signature _____ Date _____
 _____ Date _____

Therapist Signature _____ Date _____
 Michael Piciucco, LAMFT

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



Arrowhead
Family
Systems, LLC

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

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

How were you referred to me? _____

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 _____