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 correspondance? ☐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

Arrowhead Family Systems, LLC

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
- ☐ Pre-marital 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

_____

_____

Patient Signature _____ Date _____

_____ Date _____

Therapist Signature_____ Date _____

Rachel White, LAMFT- 10567

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

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 _____