Joy Oliver, LMFT Intake Form

Date:_________________________________ DOB_______________________________

Last Name____________________________________ First Name___________________

Address_______________________________________ City________________________

State________________________ Zip code__________________

Do I have permission to mail to this address?

Email address_____________________________Do I have permission to send emails?

Home Phone____________________________ Work phone_______________________

Do I have permission to contact you at home? _________________________________

If not, then how can I contact you?____

Living situation: own home____ rent ___ live with ______________________________

____

Are you currently under medical care?____

If yes, then please explain/describe____

____

Name of primary physician_____________________________Phone _________________

Are you currently taking prescribed medications?_________________________________

If yes, then please explain/describe____

____

Have you been under the care of a psychiatrist, psychologist, or counselor?__________

If yes, please give the name, date, and location of the therapy and briefly describe the nature of the problem____

____

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What do you hope to accomplish in therapy?____________________________________

____

Emergency Contact/Relation______________________________Phone______________

Coping strategies: Hobbies____

Social support network____

____

Coping skills____

Please check all the following struggles that pertain to you:

Anxiety____ Sexual problems____ Finances___ Depression___ Suicidal thoughts____

Drug/alcohol use____ Fears/phobias____ Separation/divorce____ Self-control____

Eating disorders____ Relationship concerns____ Unhappiness____ Career choices___

Anger____ Insomnia____ Health problems____ Thought patterns____ Work/stress___

Cutting/self-mutilation____ Child abuse____ Pornography____ Grief/loss_____

Family issues____ Sexual identity issues____

Is there anything else you feel I should know before we begin?_____________________

____

____

_____________________________________ __________________________________

Client's signature Date