

Charlotte Hilber, MA LMFT

Confidential Intake Form – Adult Individual

Name: _____ Date: _____

Address: _____

Street

City

State

Zip

Preferred phone number to contact me: _____ (cell home work) -OK to leave msg? Yes No

Another number to contact me: _____ (cell home work) -OK to leave msg? Yes No

Okay to contact you by mail? Yes No Age: _____ Date of Birth: _____ Gender: F M

Occupation: _____ Employer: _____

Relationship Status: NOT IN A RELATIONSHIP MARRIED _____ YEARS COHABITING-LENGTH OF TIME _____
ENGAGED-LENGTH OF TIME _____ SEPARATED -LENGTH OF TIME _____ DIVORCED- _____ YEARS WIDOWED _____ YEARS

If you were referred for therapy, who was it that referred you?

What are you hoping will be different as a result of the therapy?

FAMILY & RELATIONSHIPS

Please list other people living in the home with you:

FULL NAME	AGE	GENDER	RELATIONSHIP TO YOU

Please list any of your children living outside your home:

FULL NAME	WHO THEY ARE WITH	AGE	GENDER

HEALTH & STRESS

List any past & present physical conditions, serious illness, allergy, surgery, injury, hospitalization, & number of pregnancies:

My overall general health is: Excellent Good Fair Poor **Date of last physical exam:** _____

Do you have a religious or spiritual belief system that influences your life? No Yes: _____

Have you ever been involved with the legal system? (criminal, divorce, custody, civil, etc) No Yes: If yes, in what way?

Are you currently receiving care from a *counselor/therapist*? No Yes

Have you received care from a *counselor/therapist* in the past? No Yes (please give brief summary)

Are you currently receiving care from a *psychiatrist*? No Yes, from (name) _____

Have you received care from a *psychiatrist* in the past? No Yes

Is there any history of mental illness in your family? No Yes

Have you ever been hospitalized for psychological problems? No Yes: month & year _____

List medications presently used & what they are for: None

List medications have you taken in the past for emotional or mental problems: None

Have you experienced any of the following at any point in your life?

emotional/psychological abuse physical abuse sexual abuse none

Please check/circle all the substances you have used, past & present:

	NOW	PAST		NOW	PAST
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Other Opiates (Vicodin, Darvocet, Percodan, Oxycontin)	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	Depressants (Valium, Xanax, Rohypnol, Ativan, Klonopin, GHB, Quaaludes)	<input type="checkbox"/>	<input type="checkbox"/>
Crack/Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	Nicotine	<input type="checkbox"/>	<input type="checkbox"/>
Heroin, Chiva	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine	<input type="checkbox"/>	<input type="checkbox"/>
LSD, PCP, Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>			
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>			

When did you first use these? _____ How often do you use these? _____

How much do you currently use? _____

When did you last use? _____

Please indicate any major life stressors you experienced in the past 12 months:

death(s), family or friends serious illness/disability birth of child
 job loss(es) or change moving change in other significant relationship
 break up/divorce/marriage finances other _____

What do you consider to be your major strengths?

What do you consider to be your major weaknesses?

From whom do you get emotional support?

Is there anything else about your life or lifestyle, that would be helpful for the therapist to know?

Your Signature: _____ Date: _____