Jeff Lynch - LMFT

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INTAKE FORM
(Please complete a separate form for each person coming to counseling)

Date: _________________

Name: ______________________________ Date of Birth: ______________ Age: _______ Sex: M F

Email Address____

Address____ Phone: ____________________

May I call you there? ________ May I leave a voice mail? ________ May I text you at this number? ________

Occupation____ Phone: ____________________

Emergency Contact ____________________________________ Phone: ___________________________
(Name and Relationship)

Status (circle all that apply): Single Dating Engaged Married Remarried Separated Divorced Widowed Cohabitating

Partner's Name: __________________________ Occupation _______________ Spouse's Age: __________

Persons living with you:

Name	Age	Relationship	Where do they live?
_____________________	______	_________________________	_____________________________
_____________________	______	_________________________	_____________________________
_____________________	______	_________________________	_____________________________
_____________________	______	_________________________	_____________________________

Has your partner or other family member ever been physically violent toward you? Yes No

Religious Preference: _______________ Do you attend regularly: _____ Where: _______________________

Have you been in counseling previously? YES NO

If so, please provide the name of the counselor you saw: ____

____

Are you currently in counseling? YES NO

If so, please provide the name and location of the counselor: ____

If you answered yes to either of the previous questions, please answer the following:

a. How long have you been in counseling? Years ______ Months ______

b. How many counselors have you seen? _____

c. Was counseling for the treatment of the current problem? YES NO

Were you referred here? YES NO If yes, by whom: ____

How did you hear about this Clinic? ____

Are you on any type medication? YES NO

If yes, what medication: ____

Briefly describe your current physical health and any health problems currently being treated:

____

____

____

Who is your physician? ____

Previous major illnesses or major hospitalizations: ____

____

Current or Past History with Alcohol and/or Drug Abuse (Please Explain):

____

____

Please indicate with a check mark any of the following issues that are a concern for you at this time or have been a concern in the past. Please rank the three [3] **most important** concerns from 1, 2, 3 with 1 being the most urgent.

___ Career concerns
___ Academic concerns
___ Self-esteem
___ Grief
___ Depression
___ Sleeping difficulty
___ Eating difficulty
___ Eating disorders
___ Anxiety
___ Physical abuse
___ Emotional abuse
___ Child sexual abuse
___ Sexual assault
___ Sexual concerns
___ Sexual orientation concerns
___ Alcohol abuse
___ Other drug abuse
___ Social concerns
___ Relationship issues
___ Parent difficulty
___ Suicidal thoughts/behavior
___ Homicidal thoughts/behavior
___ Anger control
___ Violent behavior
___ Paranoia
___ Excessive fears
___ Obsessive thoughts/behavior

___ Stress
___ Panic attacks
___ Self Injury
___ Culture related issues
___ Dependency
___Homesick
___ Compulsive thoughts/behavior
___ Hallucinations
___ Pornography

Brief statement of concern (Why are you seeking counseling? What would you like to see different in your life as a result of counseling?)____

____

____

____

____

Is there any additional information you feel would help me better understand your needs? _________________

____

____

____

____

____ Signature

_________________ Date