

A. Susan Brenner, LMFT  
INTAKE FORM

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Date Of Birth \_\_\_\_\_ DX \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex \_\_\_\_\_

Employer \_\_\_\_\_

Referred By \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Ph \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

Name of Spouse/Significant Other: \_\_\_\_\_

Phone \_\_\_\_\_

Insurance Information

Name of Insured \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Relationship To Patient \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Primary Health Care Provider \_\_\_\_\_  
Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_

I give permission to consult with Primary Provider, Psychiatrist, Psychologist,  
Social Worker

**Initial** \_\_\_\_\_ **Date** \_\_\_\_\_

Release Of Information

I authorize the release of my medical or other information necessary to  
process this claim **Initial** \_\_\_\_\_ **Date** \_\_\_\_\_

I authorize payment of medical benefits directly to the provider

**Initial** \_\_\_\_\_ **Date** \_\_\_\_\_

In Case Of Emergency, Please Notify

Name \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Referred by:

Are you currently receiving psychiatric services, professional  
counseling or psychotherapy elsewhere? Yes No

Have you had previous psychotherapy?

No

Yes, Previous therapist's name \_\_\_\_\_  
phone \_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes    No

If Yes, please list: \_\_\_\_\_

If no, have you been previously prescribed psychiatric medication?

Yes    No

If Yes, please list: \_\_\_\_\_

### HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor      Unsatisfactory      Satisfactory      Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits?     No     Yes

If yes, check where applicable:

Sleeping too little       Sleeping too much       Poor quality sleep

Disturbing dreams       Other \_\_\_\_\_

4. How many times per week do you exercise? \_\_\_\_\_

Approximately how long each time? \_\_\_\_\_

5. Are you having any difficulty with appetite or eating habits?

No     Yes

If yes, check where applicable:     Eating less     Eating more

Binging     Restricting     Purging

Have you experienced significant weight change in the last 2 months?

No     Yes

6. Do you regularly use alcohol?  No  Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

\_\_\_\_\_

7. How often do you engage recreational drug use?  Daily  
 Weekly  Monthly  Rarely  Never

8. Have you had suicidal thoughts recently?  
 Frequently  Sometimes  Rarely  Never

Have you had them in the past?  
 Frequently  Sometimes  Rarely  Never

9. Are you currently in a romantic relationship?  No  Yes

If yes, how long have you been in this relationship?

\_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your current relationship? \_\_\_\_\_

10. In the last year, have you experienced any significant life changes or stressors:

**Have you ever experienced:**

Extreme depressed mood                      yes/no

Wild Mood Swings                              yes/no

Rapid Speech                                    yes/no

Extreme Anxiety                                yes/no

Panic Attacks                                  yes/no

Phobias    yes/no

Sleep Disturbances                            yes/no

Hallucinations                                 yes/no

Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no
Repetitive Thoughts (obsessions)	yes/no
Repetitive Behaviors (frequent checking)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

#### OCCUPATIONAL INFORMATION:

Are you currently employed?  No  Yes

If yes, who is your current employer/position?

If yes, are you happy at your current position?

Please list any work-related stressors, if any:

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

<b>Difficulty</b>	<b>Family Member</b>
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no
Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?