Michelle Hill
Marriage and Family Therapist Registered Intern #91401
Laguna Counseling & Expressive Arts
Employed and Supervised by Mary Felch, LMFT (MFC#36827)
(949) 359-1353

INTAKE FORM

PERSONAL DATA

DATE_____REFERRED BY_____

CLIENT: (NAME) _____ M☐ F☐

ADDRESS: _____CITY: _____ZIP CODE:_____

AGE: _____BIRTHDATE: _____

PLEASE FILL IN IF **OK** TO EMAIL: _____

HOME PHONE: ( ) _____May we call you at home? (Y) ☐ (N) ☐

WORK PHONE: ( ) _____ May we call you at work? (Y) ☐ (N) ☐

CELL PHONE: ( ) _____ May we call your cell? (Y) ☐ (N) ☐

HIGHEST GRADE COMPLETED: _____

OCCUPATION: _____

WORK ADDRESS: _____CITY: _____ZIP: _____

PREVIOIUS OCCUPATION: _____

RELIGION: _____CHURCH HOME: _____

IN YOUR OWN WORDS, PLEASE STATE THE NATURE OF YOUR MAIN PROBLEM:

_____

_____

HOW WOULD YOU RATE HOW SERIOUS THIS PROBLEM FEELS TO YOU? (CIRCLE ONE)

MILDLY UPSETTING- EXTREMELY SERIOUS

1 2 3 4 5

WHAT WOULD YOU LIKE TO ACCOMPLISH THROUGH COUNSELING?

_____

_____

GENERAL CONSENT TO THERAPY

I consent to counseling, psychotherapy and diagnostic testing as prescribed by my therapist. I agree to be responsible for the payment of $_____per session (45-50 minutes) which is payable at the time of the session. I understand that I am responsible for payment, even though my insurance company may reimburse me. I also understand that Michelle has a "no cancellation" policy and all appointments will be charged to me at the regular rate whether I attend my session or not.

Signature of Client: _____

FAMILY STATUS

PRESENT MARITAL STATUS:
Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er ☐ Significant Other ☐

IF MARRIED: # of Years Married: _____ Age of spouse: _____ Date of Marriage: _____

WOULD YOU DESCRIBE YOUR INTIMATE RELATIONS? Satisfactory ☐ Unsatisfactory ☐

IF SEPARATED: Date of separation: _____ IF DIVORCED: Date of marriage to ex-spouse: _____ Date of Divorce: _____

IF I WITH "SIGNIFICANT OTHER": His/ Her name: _____OCCUPATION: _____

DO YOU LIVE TOGETHER? N ☐ Y ☐ (for how long) _____

CHILDREN: (Names/ Ages) _____

OTHER CHILDREN LIVING WITH YOU: (Names/ Ages/ Their relationship to you) _____

_____

OTHER ADULTS LIVING WITH YOU: _____

FAMILY HISTORY

FATHER AGE: _____OCCUPATION: _____ MOTHER AGE: _____OCCUPATION: _____

STEP-FATHER: (Age) _____ STEP-MOTHER (Age) _____ Did you grow up with both parents in the home (Y) ☐ (N) ☐

DO YOU FEEL CLOSEST TO YOUR: Father? ☐ Mother? ☐ Neither? ☐

BRIEFLY DESCRIBE YOUR RELATIONSHIP WITH YOUR FATHER: _____

_____

WITH YOUR MOTHER: _____

_____

BROTHERS' FIRST NAMES AND AGES: _____

SISTERS' FIRST NAMES AND AGES: _____

PLEASE EXPLAIN IF ANY OF YOUR FAMILY HAS EVER SUFFERED FROM ANYTHING THAT COUPLD BE DESCRIBED AS AN "EMOTIONAL" OR "PSYCHOLOGICAL" PROBLEM: _____

_____

PLEASE MENTION ANY HISTORY OF DOMESTIC VIOLENCE, CHILD ABUSE OR SEXUAL ABUSE IN YOUR FAMILY: _____

_____

PLEASE COMMENT ON ANY HISTORY OF ALCOHOL OR DRUG USE IN YOUR FAMILY: _____

_____

MEDICAL HISTORY

CURRENT WEIGHT: _____ONE YEAR AGO: _____ MAXIMUM: _____ WHEN: _____

DO YOU EXERCISE REGULARLY? (Y) ☐ (N) ☐
HOW_____

DO YO SLEEP WELL? (Y) ☐ (N) ☐ Amount (Hours): _____ EASY TO GET TO SLEEP? (Y) ☐ (N)

WHAT RECREATION DO YOU ENJOY? _____

PHYSICIAN: _____ CITY: _____ DATE OF LAST PHYSICAL: _____

THE HARDEST TIME IN YOUR DEVELOPMENT WAS:

Preschool ☐ Grade School ☐ Jr. High ☐ High School ☐ College ☐ Now ☐

PLEASE INDICATE WITH AN "X" HOW OFTEN YOU EXPERIENCE ANY OF THE FOLLOWING:

	NEVER	SELDOM	SOMETIMES	OFTEN	
Nervousness	☐	☐	☐	☐	
Loss of Temper	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
Constipation	☐	☐	☐	☐	
Diarrhea	☐	☐	☐	☐	
Over-Eating	☐	☐	☐	☐	
Mood Swings	☐	☐	☐	☐	
Smoking	☐	☐	☐	☐	AMOUNT_____
Alcohol Intake	☐	☐	☐	☐	AMOUNT_____

MEDICATION AND TREATMENT HISTORY

PLEASE INDICATE WITH AN "X" HOW OFTEN YOU USE ANY OF THE FOLLOWING:

	DAILY	FREQUENTLY	OCCASIONALLY	NEVER	
Appetite Suppressants	☐	☐	☐	☐	
Aspirin	☐	☐	☐	☐	
Sedatives/Tranquilizers	☐	☐	☐	☐	
Sleeping Pills	☐	☐	☐	☐	
Stimulants	☐	☐	☐	☐	
Blood Pressure Medicine	☐	☐	☐	☐	
Heart Medicine	☐	☐	☐	☐	
Vitamins	☐	☐	☐	☐	
Others (Please specify	☐	☐	☐	☐	_____

PLEASE LIST CURRENT MEDICATIONS: _____

HAVE YOU EVER HAD ANY PREVIOUS COUNSELING OR PSYCHOTHERAPY? (Y) ☐ (N) If yes, when? _____

LENGTH OF THERAPY: _____ WAS THERAPY SUCCESSFUL? (Y) ☐ (N)

COMMENTS REGARDING PREVIOUS THERAPY: _____

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? (Y) ☐ (N) If yes, when? _____

LENGTH OF HOSPITAL STAY: _____

WHAT ARE SOME OF YOUR PERSONAL STRENGTHS? _____