Transformative Solutions

Intake Form

Name ________________________________ Home Phone ________________

Address ______________________________ Work Phone __________________

City _____________ Zip ______ Occupation/Employer _____________________

Your age _____ Date of Birth ___________

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Please rate your general satisfactions with life a present (circle one)
Very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied

Please rate your level of satisfaction in present marriage/significant relationship
Very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied

Have you had prior experience in counseling? Yes ( ) No ( )

If yes, please describe with whom, when, how long, and for what: ____________________

____

____

What are three significant problems you face currently?

1. ____

2. ____

3. ____

Is there anything in particular that you want the therapist to know about your situation?

____

____

____

Present Marriage (or significant relationship)

Years known each other ____ Years married ____ Date married _____

Children of this marriage (names/ages) Stepchildren (names/ages)

_____ _____

_____ _____

_____ _____

_____ _____

Have you been married before? ____

If one or more prior marriage(s), please list below (use back of page if more space is needed):

_____

_____

Family of Origin (Parents & Siblings)

Father's name _____

Age _____ Occupation _____

Present state of health _____

If deceased, year/cause _____

Parents still together _____ Divorced _____ Remarried _____

Mother's name _____

Age _____ Occupation _____

Present state of health _____

If deceased, year/cause _____

Brothers & Sisters	Age	Marital Status	Occupation	Location

Extended and Immediate Family History (please check those which apply)

Divorce ___ Alcohol/substance abuse ___ Physical abuse ___ Sexual abuse ___

Depression ___ Anxiety ___ Suicide ___ Mental illness ___

Other _____

Current/Recent Mood (general state lately)

Anxiety ___ Fear ___ Sadness ___ Grief ___ Anger ___ Irritability ___

Happy ___ Impatient ___ Calm ___ Numb ___

Any changes or concerns involving the following? (Please check those which apply)

Finances ___ Legal Matters ___ Work/Job ___ Education/School ___ Moving ___

Marital Status ___ Parenting ___ Concentration ___ Memory ___ Energy ___ Health/

Illness ___ Surgery/Injury ___ Grief/Loss ___ Addition of a Family Member ___ Family

Member Leaving Home ___ Sexual Activity ___ Sleep Habits ___

Eating Habits ___ Caffeine Intake ___ Tobacco Use ___ Alcohol Use ___ Drug Use ___

Your Personal Health

Identify any allergies, significant health problems, or surgeries that you have had, or currently have: _____

Do you use any medications? Yes ( ) No ( ) Any drug allergies Yes ( ) No ( )

If yes, please describe: _____

Name of your physician: _____

Other

Years & Level of Education: _____

Is Spirituality/Religion important to you? _____

Do you attend (or have you attended) any Self-Help Groups? Yes ( ) No ( ) _____

Who do you consider as your greatest support? _____

What do you consider your greatest strengths? _____

_____

How did you hear about Ther.e.pe?

____www.austintherepe.com
____www.psychologytoday.com
____www.networktherapy.com
____www.goodtherapy.org
____Google
____Referred by friend
____Referred by physician
____Saw business card or other advertisement
____ Other, Please specify_____

I, _____, understand and agree to pay costs incurred, including my co-payment or those expenses not covered by my insurance, as agreed upon with the therapist during the initial session. I understand I am responsible for sessions not cancelled 24 hours in advance. I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment, when necessary.
Re: CONFIDENTIALITY: I understand that my sessions are confidential unless I sign a release, except for the above authorization to the insurance company. I also understand that there are exceptions by law to the privilege of confidentiality. If I say I am going to harm myself or another person, my clinician may report this to the appropriate persons. If I have knowledge of abuse or neglect of a child, elderly person or disabled person, and I tell the clinician, she is obligated to report this to a state agency for follow-up. If a judge subpoenas my records, my clinician must comply. My signature below confirms that I have read and agree to the above and that I give my consent for treatment to the clinician listed herein.

Signature: _____ Date: _____

Please print name: _____ Witness: _____