In The Moment Child and Family Therapy, LLC

Individual Intake Form

Name (legal) :_____ (preferred) _____

Parent(s)/Spouse's Name : _____

Address: _____City:_____

State:_____ Zip Code:_____ Date of Birth:_____ Age:_____

Home Phone:_____ Work/Cell Phone:_____

Can we leave a message? Yes No

Marital Status: Single Married Separated/Divorced

School/Employment: _____

Education: HS/GED____ College Graduate____ Graduate Degree ____ Other____

Personal History: Briefly summarize your reason for therapy:

_____

_____

Have you been in therapy prior to today?: Yes No

Was it helpful to you? Please explain:

_____

_____

_____

Current medications:_____

Substance Use/Abuse History: Do you currently use tobacco or alcohol? Yes No

Daily/Weekly Amount? _____

Past substance use?: Yes No

Please describe:

_____

_____

Abuse History:

Have you ever been physically abused? Yes No

Sexual? Yes No

Emotional? Yes No

Currently? Yes No

Inpatient Treatment:

Have you ever been admitted for any type of inpatient treatment including emergency room visits fro suicidal thoughts, eating disorder or assault? Yes No

Please explain:

_____

Emergency Contact:

Name:_____ Phone Number:_____

Relation to you: _____

Signature:_____

Date:_____