INTAKE FORM

Please print out this form and provide the following information. Information you provide here is held to the same standards of confidentiality as therapy.

Please fill out this form and bring it to your first session or allow yourself 20 minutes prior to your appointment to complete the form in the waiting room.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Gender: ________________

Marital Status:

□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: __________ Ages ______________________________________

Local Address:

____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: _______________________________May I leave a message? □Yes □No

Cell/Other Phone: ___________________________ May I leave a message? □Yes □No

E-mail: ____ May I email you? □Yes □No
*Please be aware that email might not be confidential.

In case of emergency contact:

Name:____

Phone:____

Relationship:____

Referred by: ____

May I thank this person?____

HEALTH INFORMATION

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

□Yes □No

If yes, with whom?____

Have you had previous psychotherapy?

□Yes □ No

If yes, please list therapist's name____

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

□Yes □No

If Yes, please list names of medications:

____

If no, have you previously been prescribed psychiatric medication?
□Yes □No

If Yes, please list names of medications:

____

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

Poor Unsatisfactory Satisfactory Good Very good

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

____

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

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other ____

How many times per week do you exercise? ___________________________________

Approximately how long each time? ____

Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes, check where applicable: □ Eating less □ Eating more □ Binging
□ Restricting

Have you experienced significant weight change in the last 2 months? □ Yes □ No

Do you regularly use alcohol? □ Yes □ No

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

____

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

Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never

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

Are you currently married or in a romantic relationship? □ Yes □ No

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? _______

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

□Yes □No

If yes, please describe.

____

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 (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Intentional Self-Injury	yes/no
Homicidal Thoughts	yes/no
Thoughts of Suicide	yes/no
Suicide Attempt	yes/no

Physician's Name: ____

Date of Last Visit:____

List any drugs or medications that you are presently taking.

Have you ever been hospitalized? □Yes □No

If yes, why?____

OCCUPATIONAL INFORMATION:

Are you currently employed? □ Yes □ No

If yes, who is your current employer/position? ________________________________

Please list any work-related stressors, if any: _________________________________

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be spiritual/ religious? □ Yes □ No

If yes, what is your faith?
____

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.):

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	________________________________

Please state the reason you are seeking therapy at this time.__________________________
____

What are your goals for therapy?

____

INSURANCE INFORMATION

Do you have health insurance? □Yes □No

Does your health insurance cover outpatient treatment for mental or nervous disorders?

□Yes □No

Insurance Company Name ____

Insurance Plan Name ____

Address ____

City, State, Zip____

Telephone ____

Insured's Full Name____

Insured's Date of Birth: ____

Insured's Address ____

Insured's Phone Number ____

Insured's Employer Name ____

Policy Number ____

Group Number ____

Your Relationship to Insured: ____

Assignment of Benefits: I authorize payment of outpatient mental health benefits, allowable under my current insurance policy, directly to Miriam Koenig, LMFT, LPCC, 5535 Balboa Blvd., suite 206, Encino, CA 91316, for professional services rendered to me. If for any reason, I receive payments for these services directly from my insurance carrier, I agree to endorse the checks and deliver the same to Miriam Koenig promptly. I authorize the release of any medical or other information necessary to process claims. I also authorize the release of any information requested, in writing, by my named insurance company. I understand that I am responsible for all charges.

Signature of Client______________________________ Date ____________________

Signature of Parent/Guardian _____________________ Date _____________________
(if client is a minor)