

Rennie M. Smith, MA
Licensed Marriage Family Therapist #50238

113 Presley Way, Suite 10 ■ Grass Valley, CA 95945 rennies@sbcglobal.net (530) 913-8933

Client Intake Form

SECTION 1: Identification

NAME: _____ DATE: _____

ADDRESS: _____

CITY _____ ZIP _____

SSN: _____

Referred by: _____

Place of Employment: _____

Position/Title: _____

Phone Numbers: (H) _____

(W) _____

(C) _____

Email Address: _____

Number of Children: _____ Ages: _____

Please indicate by checking the appropriate spaces below any special circumstances related to my attempts to contact you. Keep in mind that the fewer restrictions there are on contacting you, the easier it will be for me to work out arrangements to see you.

___ Please do not call me at home.

___ You may call me at home.

May I leave a message for you if you are not there?

Yes

No

May I identify myself by name?

Yes

No

___ Please do not call me at work.

___ You may call me at work.

May I leave a message for you if you are not there?	Yes	No
May I identify myself by name?	Yes	No
May I email you?	Yes	No
May I text you about appointments?	Yes	No
Have you been court-ordered for therapy?	Yes	No

Please describe your reasons/goals for requesting services (be specific, if possible):

SECTION 2: DEMOGRAPHICS

1. What is your age? _____
2. What is your date of birth? _____
(month – day - year)
3. What is your gender?
Male Female
4. What is your marital status? _____ Name of Spouse/Partner _____
5. How long have you been together? _____
6. What is the highest level of education you attained?
 - (1) Elementary school or middle high/junior high school
 - (2) Graduated from high school or received G.E.D.
 - (3) Received vocational/technical training
 - (4) Some college
 - (5) Graduated from a 4-year college
 - (6) Received a master's or post-graduate degree
 - (7) Received a doctoral degree (Ph.D., M.D.)
7. What is your religious/spiritual background? (optional)
 - (1) Jewish
 - (2) Catholic
 - (3) Protestant
 - (4) LDS (Mormon)
 - (5) Bahai
 - (6) Other _____

Current religious affiliation and denomination: _____

SECTION 3: Mental Health History

8. Which of the following kinds of psychological/psychiatric services have you received prior to coming here? PLEASE CIRCLE ALL THAT APPLY.

- (1) None (3) Partial care (5) Other 24-hour care
(2) Outpatient therapy (4) Inpatient care

9. How many times have you received psychological/psychiatric services prior to coming here?

- (1) None (3) 3 – 4
(2) 1 – 2 (4) 5 or more, but fewer than 10 (5) 10 or more

10. Have you experienced any of the following problems? PLEASE CIRCLE ALL THAT APPLY.

- | | |
|-------------------------------------|--------------------------------------|
| (1) Anxiety | (24) Victim of abuse |
| (2) Depression | (25) Eating disorder |
| (3) Extreme mood swings | (26) Criminal behavior/incarceration |
| (4) Alcohol or drug abuse | (27) Aggression/violence |
| (5) Unusual thought or beliefs | (28) Overwhelming crisis |
| (6) Learning disability | (29) Recurrent conflicts with others |
| (7) Self-inflicted pain or injury | (30) Sexual problems |
| (8) Social isolation | (31) Other mental health problem |
| (9) No appetite | (32) Over-eating |
| (10) Always tired | (33) Always sleepy |
| (11) Unable to relax | (34) Insomnia |
| (12) Recurrent dreams | (35) Nightmares |
| (13) Hallucinations | (36) Inferiority feelings |
| (14) Feel tense | (37) Feel panicky |
| (15) Fears and phobias | (38) Obsessions |
| (16) Suicidal ideas | (39) Shy with people |
| (17) Can't make friends | (40) Afraid of people |
| (18) Poor living conditions | (41) Unable to have a good time |
| (19) Always worried about something | (42) Don't like weekends/vacations |
| (20) Can't make decisions | (43) Over-ambitious |
| (21) Financial problems | (44) Gambling |
| (22) Job problems | (45) Can't keep a job |
| (23) Other _____ | |

11. If you have ever attempted suicide, when did your most recent attempt occur?

- (1) I have never attempted suicide
- (2) Within the last month
- (3) More than 1 month ago, but within the last year
- (4) More than 1 year ago, but less than 5 years ago
- (5) More than 5 years ago

12. Has any other member of your family previously sought or received psychological or psychiatric counseling?

- (1) No
- (2) Yes

13. Has anybody else in your family experienced any of the following problems?

PLEASE CIRCLE ALL THAT APPLY.

- | | |
|---------------------------------|-------------------------------------|
| (1) Anxiety | (7) Developmental delays |
| (2) Depression | (8) Suicide |
| (3) Extreme mood swings | (9) Criminal behavior/incarceration |
| (4) Alcohol or drug abuse | (10) Aggression/violence |
| (5) Unusual thoughts or beliefs | (11) Attention deficit disorder |
| (6) Learning disability | (12) Other mental health problem |

SECTION 4: Medical History

14. Have you had a physical examination within the last six months? (1) No (2) Yes

15. Have you seen a physician or other health care professional within the last six months for reasons other than a physical checkup? (1) No (2) Yes

If yes, please specify reasons: _____

16. Please circle any of the following that you have experienced either currently or in the past:

- | | |
|--------------------------------|--|
| (1) Headaches | (9) Ulcers |
| (2) Dizziness | (10) High blood pressure |
| (3) Fainting spells/blackouts | (11) Thyroid difficulties |
| (4) Severe or prolonged nausea | (12) Diabetes |
| (5) Seizures or convulsions | (13) Hypoglycemia (low blood sugar) |
| (6) Memory loss | (14) Heart disease |
| (7) Allergies | (15) Other heart condition (e.g., heart murmur, mitral valve prolapse) |
| (8) Asthma | |

17. How many serious injuries (that needed medical attention) have you had?

18. How many surgeries have you had? _____

19. Please describe major illnesses, surgeries and/or serious injuries and dates:

20. Please list current drugs or medications, average dose, and frequency:

20. Who is currently monitoring your medication (if any) for psychological problems?

21. If there are any other medical or physical problems, which you feel might be important to my ability to be of help to you, please explain here:

22. Who is your current physician? _____

23. Please list the people in your household: _____