Kari Lloyd-Fisher, MFT

Licensed Marriage Family Therapist

NEW CLIENT INTAKE FORM – Please fill out this form and bring it to your first session.

Today's Date:_____ Referred by_____

GENERAL INFORMATION

Minor's Name: _____ Date of Birth: _____

Name of Parent(s)/Legal Guardian(s): _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ May I contact you at home?: ☐ Yes ☐ No
(Messages OK?) ☐ Yes ☐ No

Work Phone: _____ May I contact you at work?: ☐ Yes ☐ No
(Messages OK?) ☐ Yes ☐ No

Cell Phone: _____ May I contact you on your cell?: ☐ Yes ☐ No
(Messages OK?) ☐ Yes ☐ No

Children or others living in the home: _____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

Name of Emergency Contact:_____ Relationship: _____

Emergency Contact's Phone #: _____

School: _____ Grade: _____

GPA/Performance: _____ Problems/Special Services: _____

PURPOSE FOR VISIT

What brings you into therapy today? _____

_____

_____

When did the issue arise? _____

CLIENT NAME: _____ DATE: _____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)
None =This symptom not present at this time ● **Mild** =Impacts quality of life, but no significant impairment of day-to-day functioning ● **Moderate** =Significant impact on quality of life and/or day-to-day functioning ● **Severe** =Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed Mood	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐	Delusions	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐	Hallucinations	☐	☐	☐	☐
Fatigue/Low Energy	☐	☐	☐	☐	Aggressive Behaviors	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐	Bingeing/Purging	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐	Anorexia	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Self-Mutilation	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐	Weight Loss/Gain	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Hopelessness	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Grief	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐	Sexual Problems	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐	Phobias	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐	☐

PSYCHIATRIC HISTORY

☐ Yes ☐ No Prior suicide attempts?
If yes, when? _____
Circumstances that led to the attempt: _____
_____
_____
_____

☐ Yes ☐ No Current suicidal thoughts?
If yes, please describe: _____
_____
_____
_____

☐ Yes ☐ No Prior outpatient therapy?
If yes, when and for how long? _____
What was the focus of previous treatment? _____
_____
Was it helpful? _____

☐ Yes ☐ No Prior hospitalization for mental/emotional problems?
If yes, please describe (year/duration/reason for hospitalization): _____
_____
_____
_____

CLIENT NAME: _____ DATE: _____

MEDICAL HISTORY

□ Yes □ No Are you currently taking any prescription medication.
If yes, please provide name of medication(s)/dose/prescribing Physician: _____
_____
_____
_____

□ Yes □ No If yes, are any of these medications for mental/emotional problems?

□ Yes □ No Do you have any medical conditions that may affect your treatment?
Please describe your overall health today: _____
_____
_____
Date of last visit to Physician: _____

□ Yes □ No Do you drink alcohol?
If yes, how much do you consume in a week?: _____

□ Yes □ No Do you currently use drugs (not including prescriptions above)?
If yes, please describe your drug use: _____
_____
_____

PRENATAL/DEVELOPMENTAL HISTORY OF MINOR

Any use of drugs or alcohol during pregnancy with minor? _____

Problems during pregnancy or delivery of minor? _____

Congenital defects? (If yes, specify) _____

Age at which minor: Sat up _____ Crawled _____ Stood alone _____ Walked _____

First Words _____

Age at which potty-trained _____ Length of time to train _____ Soiling or bedwetting? Yes No

List any history of seizures, prolonged high fevers, head injuries, poisoning, serious illness or injury:

_____

_____

_____

List any prolonged separations or traumatic events in childhood

_____

_____

_____

CLIENT NAME: _____ DATE: _____

ADDITIONAL INFORMATION

What do you consider to be your strengths?: _____

_____

_____

_____

_____

What do you like most about yourself?: _____

_____

_____

_____

_____