INTAKE FORM
MINDFUL GUIDES, A MFT CORP.
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Client's Name:____________________________Age:__ D.O.B. ______Sex: M F Marital Status:__________
Client's Address:____
Home Phone #:_______________________Cell Phone#:_____________________OK to leave messages? Y N
OK to send text messages? Y N Others living in the home:____
Email :______________________________________Occupation:__________________Education:_____________
Emergency Contact:________________________Phone#:______________

PRESENTING PROBLEM(S)

Please describe the reasons for seeking counseling (include date/month the problem started and level of severity):
____
____
____
____
____

Suicide attempts or violent behavior, past and/or present? (describe: ages, reasons, circumstances, how, etc)
____
____
____

HISTORY OF PRESENT PROBLEM

Please indicate how the following symptoms/problems/complaints are affecting you: (leave blank if no effect)
1) Little effect 2) Some effect 3) Much effect 4) Significant effect

___Eating habits/Appetite: eating more; eating less; weight change ____; binge; purge.
___Sleep: trouble falling asleep; trouble staying asleep; trouble waking up; average #hours sleep___; #naps
___Decreased energy/Fatigue
___Sexual functioning
___Loss in interest in activities
___Tearfulness
___Hopelessness/Helplessness
___Inattentive/Distractible
___Memory; long term; short term
___Difficulty planning ahead
___Anger outbursts
___Impulse control; difficulty controlling physical behavior/hyperactive
___Mood changes
___Anxious/nervous/worry/fear
___Stealing
___Lying
___Police/probation involvement
___Spending sprees
___Rapid heartbeat
___Phobia
___Sweating
___Trouble breathing
___Flashbacks of traumatic event
___Nightmares
___Racing thoughts
___Hearing Voices
___Seeing things that are not there

HISTORY OF SUBSTANCE USE

-Coffee (#___cups/daily) -Cigarettes (#___per day) -Alcohol (#___drinks /weekly) Date last drank: _____

Street Drugs:

Type: ___________________Amount: _________________Frequency: __________Date last used: ________

Prescription Drugs:

Type: ___________________Amount: _________________Frequency: __________Date last used: ________

Describe impact of substance abuse/use on your life:

____

____

Past treatment for substance use:

____

____

Family history of substance use:

____

____

PSYCHOSOCIAL HISTORY/FUNCTIONING

Rate how the problems/symptoms/complaints are impacting areas of functioning:

1) Mild 2) Moderate 3) Severe

___Marriage/Relationship

___Work/School

___Family

___Friendships

___Financial Situation

___Physical Health

___Social Interests

___Leisure activities

___Housing

___Attending to daily living activities (i.e. shower, grooming, self-care, etc.)

___Spirituality

___Current Stressors

Other____

Current Partner:____Years: ______________

PARTNER's: Education: ______________ Occupation: ______________________________________

Nature of your relationship:

____

____

PAST Partners (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

____

____

____

____

Childhood experiences (your feelings growing up, emotional climate of childhood home, describe any changes in your family of origin, including: moves, job changes, significant events, deaths, separations from parents, divorce, major illness, or injuries):

____

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____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

____
____
____
____
____

WHAT DO YOU SEE AS STRENGTHS: ____

WHAT DO YOU SEE AS WEAKNESSES:____

GOALS FOR TREATMENT:

____
____

MOTIVATION FOR TREATMENT:

____
____

PAST TREATMENT HISTORY

Psychiatric or psychological treatment of any kind before? YES___ NO___

If Yes, please answer the following:

What type of care was received? Inpatient___ Outpatient___ Both___

When was the treatment?______________________________

How long was the treatment?___________________________

Name of the therapist or doctor?______________________

Was there prescribed medication at that time? YES___ NO___ NOT APPLICABLE___

If yes, what was prescribed (include dosages if known)?_____________________________________

____

Family history of psychiatric treatment:

____
____

Family members currently in psychiatric treatment:_______________________________________

MEDICAL HISTORY

Any past/current medical problems/surgeries:

____
____

Date of last physical exam:_________________________

Current Medications/Remedies: (Dosage, frequency, M.D./Practitioner prescribing and why)__________________

____
____

Over the Counter Medications:____

Client Allergies: ____

Significant family medical history (including illness that runs in the family) and allergies:

____
____
____

Authorization to communicate with current/previous providers: YES___ NO___

Provider Name:_______________________________ Phone #:_____________________________

Provider Name:_______________________________ Phone #:_____________________________

Provider Name:_______________________________ Phone #:_____________________________

Other information you would like me to know:

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______________________________ ______________
Client/Legal Representative Signature Date

______________________________ ______________
Client/Legal Representative Signature Date