

INTAKE FORM
MINDFUL GUIDES, A MFT CORP.
7734 Herschel Avenue, Suite I La Jolla, CA 92037

Client's Name: _____ Age: __ D.O.B. _____ Current Gender Identity: _____
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):

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

ETHNICITY AND/OR RELIGIOUS AFFILIATION: _____

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:

Client/Legal Representative Signature

Date

Client/Legal Representative Signature

Date