OC Couple and Family Therapy

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Intake Information

Name:_____

Date of Birth: _____ Age:_____ Gender:_____

Home Address: _____City:_____ Zip Code:_____

Home Phone #:_____ Cell Phone:_____

Occupation:_____ Religion: _____

Email Address:_____@_____

Spouse/partner Information:

Name:_____

Date of Birth: _____ Age:_____ Gender:_____

Home Address: _____City:_____ Zip

Code:_____ Home Phone #:_____ Cell

Phone:_____ Occupation_____

Email Address:_____@_____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Children:

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Psychiatric History

Current therapist:_____

Past therapist: _____

Current Psychiatrist: _____

Medication currently using:

Medication	Dosage	Using as prescribed?

Please check any of the following conditions or problems that you are dealing with currently or have dealt with in the past?

- ☐ Academic problems
- ☐ ADHD
- ☐ Adolescent rebellion
- ☐ Aggression
- ☐ Alcohol abuse
- ☐ Anxiety
- ☐ Chronic stress
- ☐ Depression
- ☐ Domestic violence
- ☐ Eating problems
- ☐ Emotional abuse
- ☐ Hallucinations
- ☐ Homicidal thoughts
- ☐ Legal issues
- ☐ Work problems
- ☐ Panic attacks
- ☐ Phobias
- ☐ PTSD
- ☐ Rape
- ☐ Relationship difficulty
- ☐ Self injurious bx
- ☐ Sexual abuse
- ☐ Sexual identify issue
- ☐ Sexual problems
- ☐ Sleep problems
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Substance abuse
- ☐ Trauma

Family History (check all that apply):

- ☐ Depression
- ☐ Suicide
- ☐ Bi Polar disorder
- ☐ Schizophrenia
- ☐ Alcohol abuse
- ☐ Developmental disabilities
- ☐ Drug Abuse
- ☐ Incarcerated

What are you seeking therapy for?

How did you hear about our service?

_____ _____

Client Signature Date