

**Contessa Strother, M.S., MFT, LPCC**

Couples, Premarital and Individual Therapy

**Mission Valley**

2535 Camino Del Rio S. Suite 230

San Diego, Ca 92108

**Bankers Hill**

2214 5<sup>th</sup> Ave.

San Diego, ca 92101

858.777.9707

contessastrother.com

**Client Intake Form (Adult)**

**General:**

Name \_\_\_\_\_

Date \_\_\_\_\_ Address \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_ Referred by \_\_\_\_\_

Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Marital status \_\_\_\_\_ Educational level \_\_\_\_\_

Occupation \_\_\_\_\_ Names and ages of children \_\_\_\_\_

Emergency contact information \_\_\_\_\_

Explanation of how patient may be contacted by therapist \_\_\_\_\_

Patient Questionnaire/Intake 2

**Financial Information:**

Annual household income \_\_\_\_\_ Do you own or rent? \_\_\_\_\_

How do you intend to pay for treatment? (cash, check, charge, insurance) \_\_\_\_\_

***If planning to use health insurance:***

Name of insurance company \_\_\_\_\_

Policy number \_\_\_\_\_ Group number \_\_\_\_\_

Telephone number \_\_\_\_\_ Primary card holder \_\_\_\_\_

Co-pay \_\_\_\_\_

**Areas of Concern**

What issues/concerns causes you to seek treatment? Please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any specific goals with regard to your treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any particular concerns/fears with regard to treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Psychological History:**

Have you ever received mental health treatment before? \_\_\_\_\_

When and for how long? \_\_\_\_\_

What was the focus of treatment? \_\_\_\_\_

Name of treating therapist(s), address(es), telephone number(s) \_\_\_\_\_

(An authorization for release of confidential information will be needed if any former therapist is be contacted during your treatment, if it is deemed appropriate.)

Have you ever been hospitalized for mental or emotional problems? \_\_\_\_\_

When and for how long? \_\_\_\_\_

Why were you hospitalized? \_\_\_\_\_

Are you currently taking any prescription medications (Please list if so)? \_\_\_\_\_

Prescribed by whom? \_\_\_\_\_ Are you currently seeing a psychiatrist? \_\_\_\_\_

If so please indicate whom \_\_\_\_\_

How long have you been on the medications? \_\_\_\_\_

Have you ever taken any medications for a mental or emotional condition? \_\_\_\_\_

When and for how long? \_\_\_\_\_

Have you ever attempted suicide? \_\_\_\_\_

When? \_\_\_\_\_

Describe the circumstances that led to that attempt. \_\_\_\_\_

Are you currently having any suicidal thoughts? Please describe \_\_\_\_\_

Please describe your childhood. \_\_\_\_\_

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe. \_\_\_\_\_

Have you ever been a victim of a violent crime? Please describe \_\_\_\_\_

**Medical History**

Have you ever been diagnosed with a serious illness? Please describe \_\_\_\_\_

Do you have any medical conditions that may affect your mental health treatment? \_\_\_\_\_

Please describe your overall health today. \_\_\_\_\_

Primary Physician \_\_\_\_\_ phone: \_\_\_\_\_

Date of last physical \_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of children \_\_\_\_\_

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. \_\_\_\_\_

Have you ever been in a 12-step program? Please describe. \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_

On average, how much alcohol do you consume in a week? \_\_\_\_\_

Do you currently use illegal drugs? Please describe your use \_\_\_\_\_

Have you ever used illegal drugs? Please describe. \_\_\_\_\_

**Family of Origin History**

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. \_\_\_\_\_

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. \_\_\_\_\_

Names and ages of siblings. \_\_\_\_\_

**Other Information**

Please describe your spiritual identity/orientation. \_\_\_\_\_

Please describe your interests/hobbies \_\_\_\_\_

Are you now or have you ever been involved in a lawsuit? \_\_\_\_\_

Please describe. \_\_\_\_\_

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. \_\_\_\_\_

**If being seen for Couples Therapy please complete the following questions:**

1. What is the problem that led you to decide to come to couples therapy?
2. How long have you and your partner been together? In what form (e.g., dating, living together, married)?
3. What initially attracted you to your partner?
4. How long has it been since things were good between the two of you? What caused things to go downhill after that?
5. On a scale of 1 to 10, describe your level of commitment to your relationship (1=not at all, 10=extremely). Explain the rating you give yourself.
6. What role have you played in contributing to the problems in your relationship; what tendencies do you have and what actions have you taken that have helped create or have added to the difficulties between you two?
7. What are the things you like most about your relationship, or have in the past?