Bridge Counseling Group, MFC #39867

5006 Sunrise Blvd,
Suite 104 Fair Oaks, CA 95628
Phone (916) 557-8881

Intake Form for Adult Psychotherapy

Name: ______________________________ Date: _______________

Address: ____________________ City: _________ State: _____ Zip: ______

Home Phone: ______________ Cell: ______________ Work: ______________

Email: ________________________ Referred by: __________________

Please indicate if messages can be left or mail sent to:

Home Phone: ☐Yes ☐No Work Phone: ☐Yes ☐No

Cell Phone: ☐Yes ☐No Home Address: ☐Yes ☐No

In case of emergency, please contact: ______________ Phone: ______________

Relationship: ______________________________

Date of Birth: _______________ Social Security No. ______-______-________

Age: _______ Marital Status: ☐S ☐M ☐W ☐Sep. ☐Div. No. of Years Married: _____

Spouse's Name: ____________________________

Children (names & ages):

____

____

____

____

Place of Employment: __________________ Occupation: __________________

Responsible Party information:

Name: ________________________ DOB/Age: ____________/________

Affiliation? (spouse, parent, etc.) ______________________________

Briefly describe why you are seeking therapy at this time.

____

____

____

Primary Care Physician: ________________________Phone:____________________

Do we have your permission to coordinate care with your Primary Care Physician? ☐ Yes ☐No   Date of last physical examination: _______________________________

Treating Psychiatrist: ____________________________ Phone: __________________

Current Medications	Dosage	Prescribing Physician
________________________	______________	__________________________
________________________	______________	__________________________
________________________	______________	__________________________
________________________	______________	__________________________

Previous Therapist: __________________________ Date of Service: ______________

Issues addressed in therapy: ____

____

Do you have any medical conditions that you are being treated for? ☐Yes ☐No

If so, please explain: ____

____

If you have ever been hospitalized, please list when and for what reason (Please include pregnancy and abortion). ____

____

Have you ever experienced any trauma in your life? ☐Yes ☐No

If so, please briefly explain: ____

____

____

List five (5) things about yourself that you like: _________________________________

____

____

____

List five (5) things about yourself that you would like to change: ___________________

____

____

What are your major strengths? ____

____

____

Have any anniversaries of importance or stressful events in your life occurred recently? Are any due to occur soon? ____

____

List any major problems or stressful events that other family members or close friends are currently dealing with: ____

____

____

What solutions or efforts have you tried to solve resolve the problems that bring you here? ____

____

Do you have any religious affiliation? ☐Yes ☐No If so, what denomination: __________

Are you ☐practicing or ☐non-practicing in your faith?

Family History

Relationship	Name	Living	Deceased	Age	If living, location
Mother	________________	☐	☐	_________	____________________
Father	________________	☐	☐	_________	____________________
Brother	________________	☐	☐	_________	____________________
Brother	________________	☐	☐	_________	____________________
Sister	________________	☐	☐	_________	____________________
Sister	________________	☐	☐	_________	____________________

Is there any family history of mental illness? ☐Yes ☐No

Are there issues with your family origin that you believe are influencing the quality of life today? If so, please describe:

____

____

____

Do you drink alcohol? ☐Yes ☐No

If so, how much beer, wine or hard liquor do you consume each week on the average?

____

Have you ever felt the need to cut down on your drinking? ☐Yes ☐No

Have you ever felt annoyed by criticism about your drinking? ☐Yes ☐No

Have you ever felt guilty about your drinking? ☐Yes ☐No

Have you ever had a Driving Under the Influence arrest? ☐Yes ☐No Date:

Do you smoke cigarettes? ☐Yes ☐No How many packs per day? ________________

Do you have any compulsive behaviors that you would like to address in therapy? If so, please list.

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____

____

Do you have any other information that you feel is important for me to know?

____

____

____

Please check all issues that apply:

__ Depressed mood	__Gender issues	__Co-dependency
__Eating disturbance	__Alcohol/drug use	__Sexual disturbance
__Physical abuse	__Sleep disturbance	__Obsessive/Compulsive
__Hallucinations	__Sexual abuse	__Substance abuse (past)

__Low self-esteem	__Aggressive behaviors	__Substance abuse (present)
__Phobias/fears	__Suicidal thoughts	__Other ____________________
__Chronic pain	__High stress	
__Avoidant behaviors	__Social skills problems	
__Panic attacks	__Relationship issues	
__Anger/temper	__Low energy/fatigue	