Sarah Wood, MS, LMFT

LICENSED MARRIAGE AND FAMILY THERAPIST

250 W. First Street, Suite 214 • Claremont, CA 91711
(626) 275-8935

Client Intake Information

Name _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Preferred phone: _____ OK to leave messages?: □ Yes □ No

Alternate phone: _____ OK to leave messages?: □ Yes □ No

Email: _____OK to send email? □ Yes □ No
* Please note: Email correspondence is not considered to be a confidential medium of communication.

Ethnicity: _____ Gender Identity: _____

Marital Status: □ Single □ Married/Partnered □ Divorced □ Separated □ Widowed

Spouse/Significant Other Name:_____ Age _____

If client is a minor, please list names and contact information of parents/guardians:

Parent/Guardian #1: Name _____ Age _____

Address _____ City _____ State _____ Zip _____

Preferred phone: _____ OK to leave messages?: □ Yes □ No

Alternate phone: _____ OK to leave messages?: □ Yes □ No

Parent/Guardian #2: Name _____ Age _____

Address _____ City _____ State _____ Zip _____

Preferred phone: _____ OK to leave messages?: □ Yes □ No

Alternate phone: _____ OK to leave messages?: □ Yes □ No

Others living in the home, including children:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Who should I contact in case of an emergency? _____

Relationship: _____ Phone: _____

What brings you to therapy? Please be as specific as you can.

In the past 3 months, have you experienced significant symptoms of any of the following?

□ Aggression	□ Difficulty concentrating	□ Hyperactivity	□ Racing thoughts
□ Anger	□ Disordered eating	□ Hyperarousal	□ Self-blame
□ Anxiety/worry	□ Dissociation	□ Insomnia	□ Self-harm behaviors
□ Apathy/Lack of interest	□ Emotional numbing	□ Irritability	□ Sexual acting out
□ Avoidance	□ Fatigue/low energy	□ Memory problems	□ Sexual dysfunction
□ Compulsive behaviors	□ Fear	□ Mood swings	□ Social isolation
□ Crying/sadness	□ Flashbacks	□ Nightmares	□ Somatic complaints
□ Delusions	□ Guilt	□ Obsessive behaviors	□ Other:_____
□ Denial	□ Hallucinations	□ Panic attacks	_____
□ Depressed mood	□ Harm or threat to others	□ Phobias	_____

Have you ever attempted suicide? □ Yes □ No Have you ever had thoughts of suicide? □ Yes □ No

If yes to either of the above, please describe: _____

Have you ever tried to hurt someone else? □ Yes □ No

If yes, please describe: _____

Please describe any significant life changes or stressful life events have you experienced recently:

How often do you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

How often do you use recreational drugs? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Please check all of the drugs you use currently or have used in the past:

□ Amphetamines/speed □ Hallucinogens □ Opiates
□ Barbituates/downers □ Inhalants □ Prescription
□ Cocaine/Crack □ Marijuana/hash □ Other: _____

Have you ever been diagnosed with a mental illness/disorder? □ Yes □ No

If yes, please specify: _____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Are you currently taking prescribed psychiatric medication? □ Yes □ No

If yes, please specify when, what kind, and purpose: _____

_____

_____

Have you received outpatient psychotherapy previously? □ Yes □ No

If yes, please specify when, how long, and focus of treatment: _____

_____

_____

Have you ever been hospitalized for psychological/psychiatric reasons? □ Yes □ No

If yes, please specify where and what happened: _____

_____

_____

Please identify family history of any of the following:

Alcohol/Substance Abuse □ Yes □ No
Anxiety/Phobias □ Yes □ No
Bipolar Disorder □ Yes □ No
Depression □ Yes □ No
Family Violence/Abuse □ Yes □ No

Eating Disorder □ Yes □ No
Schizophrenia □ Yes □ No
Suicide Attempts □ Yes □ No

Other: _____

_____

Are you currently involved in any legal cases? □ Yes □ No On probation or parole? □ Yes □ No

If yes to either of the above, please describe: _____

_____

_____

Please describe any current physical health problems/concerns: _____

_____

_____

Are you currently taking any medication for physical health problems? □ Yes □ No

If yes, please list name and dosage of medication(s), and reason for taking: _____

_____

_____

Are you allergic to any medications? □ Yes □ No If yes, specify: _____

Do you consider yourself to be spiritual or religious? □ Yes □ No

If yes, please describe: _____