Selin E. Caka, MA, LMFTA

Intake Form

Client's Name: _____ Sex: _____ Age: _____ DOB: _____

Street Address:_____ City: _____ State: ____ Zip: _____

Cell: _____ Home: _____ Office: _____

OK to send postal mail? _____ OK to leave voice mail on: Cell ____ Home: _____ Office: _____

Primary Care Doctor _____ Date last seen _____

Psychiatrist _____ Date last seen _____

What brings you to therapy?

Current symptoms (please rate severity):

0 *= Not present at this time*

1 *= Impacts quality of life, but day-to-day functioning is not impaired*

2 *= Significant impact on quality of life and/or day-to-day functioning is impaired*

3 *= Profound impact on quality of life and/or day to day functioning*

	0	1	2	3		0	1	2	3		0	1	2	3
depressed mood					bulimia					hyperactivity				
anxiety					anorexia					losing track of time/place				
appetite disturbance					laxative abuse					somatic complaints				
sleep disturbance					diuretic abuse					significant weight change				
elimination disturbance					paranoid ideas					a medical condition				
fatigue/low energy					racing thoughts					emotional trauma				
slow movements					delusions					physical trauma				
poor concentration					visual hallucinations					sexual trauma				
poor grooming					audio hallucinations					domestic violence				
mood swings					aggression					self-mutilation/self-harm				
agitation					sexual dysfunction					suicidal thoughts				
emotionality					grief					other_____				
irritability					hopelessness					other_____				
panic attacks					social isolation					other_____				
phobias					guilt					other_____				
obsessions					feeling worthless					other_____				
compulsions					elevated mood					other_____				

Which of the above issues or symptoms is your highest priority?

MENTAL HEALTH/PSYCHIATRIC HISTORY

Have you had prior *outpatient* psychotherapy? _____

Provider Name	Dates of treatment	Diagnosis (if applicable)

Therapeutic modalities/interventions used:

Which of these did you find helpful? Which were not helpful? Please briefly describe:

Have you had prior *inpatient* treatment for psychiatric issues? _____

Facility Name	Dates of treatment	Diagnosis (if applicable)

Therapeutic modalities/interventions used:

Which of these did you find helpful? Which were not helpful? Please briefly describe:

FAMILY COMPOSITION

Please list everyone currently residing in your home, starting with yourself:

Name	Relationship	Gender	Age	Quality of relationship

Please list any other important people in your life, living outside your home:

Name	Relationship	Gender	Age	Place of Residence	Quality of relationship

Please list any other important people who are no longer in your life, but still impact you:

Name	Relationship	Gender	Your age at separation	Quality of relationship

EMPLOYMENT

Are you currently employed? _____

If yes, where are you employed?

What are your job duties?

How long have you held this position? _____

If you are not currently employed, are you actively seeking employment?

Please describe:

Are you a member of the US armed forces? _____

Which branch? _____

Are you currently on active duty? _____

Have you been deployed overseas, or served in combat? _____

If so, please describe:

Do you receive SSI or other disability?

If so, please explain:

SUBSTANCE ABUSE

Are you currently abusing alcohol or other addictive substances? _____

If so, please explain:

Have you ever had inpatient or outpatient substance abuse treatment? _____

Facility Name	Dates of treatment

Was it beneficial? _____ Why or why not?

CULTURAL/ETHNIC IDENTITY

How would you describe your cultural and/or ethnic heritage?

On a scale of 0-10, how connected do you feel to this heritage? _____

Are any languages other than English spoken in your home? _____

Which languages?

SPIRITUAL/RELIGIOUS AFFILIATION:

Do you practice, or have you practiced, a faith-based religion or spiritual pursuit? _____

Please describe:

On a scale of 0-10, how important to this practice in your daily life? _____

MEDICAL HISTORY

Are you currently undergoing treatment or receiving care for a medical condition? _____

If so, please describe:

Are you receiving treatment or services for any physical, developmental, or cognitive concerns? _____

If so, please describe:

Are you taking medication? _____

If so, please complete the following:

Medication name	Daily dose	Reason prescribed	Dates taken

TRAUMA HISTORY

Please briefly describe any traumatic events or losses you have endured:

DOMESTIC VIOLENCE

Have you ever experienced physical and/or verbal abuse? _____

Please briefly describe:

LEGAL HISTORY

Are you currently experiencing any legal difficulties? _____

Please describe:

Do you have a history of past legal involvement? _____

Please describe:

Please take a moment to note any concerns or questions you might have about process of therapy:

EMERGENCY CONTACT INFORMATION

Please provide an emergency contact should an emergency situation arise during our work together:

Name	Phone Number	Relation to you

How did you hear about me?