# Patrea Miller, MFT

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**INTAKE AND INITIAL ASSESSMENT FORM**

**Confidential Document** Date:_____

Name:_____

Address:_____

City/State/Zip:_____ Emergency Contact:_____

Home Phone:_____ Contact #:_____

Cell_____ Referral source:_____

Work Phone_____ Occupation:_____

Male/Female Age:___ DOB_____ Fee:_____

Presenting Issue:

What has prompted you to seek out therapy?

Have you had any losses, trauma, or crisis?

**Symptoms**: Depression Mania Mood swings Panic attacks Phobias Avoidance Physical Pain

Repetitive thoughts Flashbacks Nightmares Memory Grooming Alertness Learning Disability

Loss of Appetite

Other :_____

Suicidal Ideation:_____

Addictions History:_____

Self -Endangerment History:_____

Therapy/Treatment History: None Individual Couples Family Group Inpatient Outpatient

Name of Previous Therapist/How Long:_____

Outcome of Therapy_____

Psych Meds:_____

Hospitalizations:_____

Medical History: Good Health Some Challenges Chronic Acute

_____

_____

Physician:_____

Recent Health Changes:_____

Other medications:_____

Sleeping patterns:_____

Eating patterns:_____

Weight gain or loss:_____

Family health concerns:_____

Family of Origin: *(Who's in your immediate/extended family?)*

Education:_____

Current Support System: (Living situation, relationships, friendships):

Cultural/Ethnic/Sexual Orientation/Spirituality:

Relationship to School/Work/Exercise/Leisure activities/Community:

Strength (*What makes you feel content?*):

Coping mechanisms: *(What do you do when you are mad, sad, feeling good? How do you deal with your emotions?)*:

Current Goals: *(What are you looking for from therapy? What does successful therapy look like? What changes do you want to make and how?)*:


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