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**COUNSELING INTAKE FORM**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Referral Source \_\_\_\_\_

Ethnicity/Family Heritage \_\_\_\_\_ Religious/Spiritual belief system \_\_\_\_\_

\_\_\_\_\_ Do you feel you have a strong social support network ?

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

Education \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

Employer \_\_\_\_\_ Job Title \_\_\_\_\_ Date Employed \_\_\_\_\_

Past Employment History \_\_\_\_\_

Presenting Problem \_\_\_\_\_

When did problem begin? \_\_\_\_\_

How often does problem occur? \_\_\_\_\_

Are there any triggers you are aware of that increase the problem behavior? \_\_\_\_\_

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On a scale of 1 to 10, with 10 being the most severe, how would you rate the severity of your problem? \_\_\_\_\_

How long does presenting problem typically last? \_\_\_\_\_

What do you hope to achieve with therapy? \_\_\_\_\_

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**Medical/Mental Health History**

General Health \_\_\_\_\_

Are you currently under a doctor's care? \_\_\_\_\_ If yes, name of doctor \_\_\_\_\_

Reason for doctor's care \_\_\_\_\_

Are you taking any medication? \_\_\_\_\_ If yes, please list (including OTC) \_\_\_\_\_

Reason for medication \_\_\_\_\_

Last medical examination \_\_\_\_\_

Have you ever been hospitalized for a physical or mental illness? \_\_\_\_\_

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

Do you smoke? \_\_\_\_\_ Do you take drugs? \_\_\_\_\_ If yes, what kind?

Do you drink alcohol? \_\_\_\_\_ If yes, how many drinks per week? \_\_\_\_\_

Do you have a history of substance abuse? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

Prior Therapy/Counseling? \_\_\_\_\_ If yes, please describe (when, where, how long, reason) \_\_\_\_\_

**Family Systems Information**

Where born \_\_\_\_\_ How long there \_\_\_\_\_

Father alive? \_\_\_\_\_ Where residing \_\_\_\_\_

Relationship \_\_\_\_\_  
\_\_\_\_\_

Mother alive? \_\_\_\_\_ Where residing \_\_\_\_\_

Relationship \_\_\_\_\_  
\_\_\_\_\_If reared by someone other than your birth parents, please describe \_\_\_\_\_  
\_\_\_\_\_Siblings (include gender and ages) \_\_\_\_\_  
\_\_\_\_\_

Parents Divorced? \_\_\_\_\_ If yes, your age at time \_\_\_\_\_

If deceased, what year? \_\_\_\_\_ Cause of death \_\_\_\_\_

Any step-parents? \_\_\_\_\_ If yes, describe relationship with them \_\_\_\_\_  
\_\_\_\_\_Family Substance Abuse and/or Domestic Violence? \_\_\_\_\_ If yes, please describe  
\_\_\_\_\_Sexual Addictions and/or Abuse? \_\_\_\_\_ If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Marital Status \_\_\_\_\_ # of marriages \_\_\_\_\_ Spouse's name \_\_\_\_\_

Living with a partner? \_\_\_\_\_ How long \_\_\_\_\_ Partner's name \_\_\_\_\_

Children (include gender and ages) \_\_\_\_\_  
\_\_\_\_\_

