Slater & Associates, LLC

Therapy Intake Form

Patient's Name: _____DOB: _____Age:_____
First Middle Last

Address: _____ City: _____ Zip:_____

E-Mail Address: _____

Occupation: _____ Employer:_____

Education Level (circle one): HS Bachelor Master Doctorate

Number of Marriages: _____ Gender (circle one): M F

Relationship Status (check one) ____Single _____ Married _____ Divorced ____Committed Relationship

Home Phone: _____ OK to leave message? Y N
Cell Phone: _____ OK to leave message? Y N
Work Phone: _____ OK to leave message? Y N

Family Information (If a minor or a family):

Mother: _____ Phone: _____
Address: _____ City_____Zip_____
Father: _____ Phone: _____
Address: _____ City_____Zip_____

Parent's relationship status (circle one)

Married Divorced Never Married

Current Custody (circle one): Joint Sole Split

Current Timesharing Arrangement:
Mother: **Father:**

Please list below all family members living in the household:

Name	Age	Gender	Relationship

Medical History (Patient):

Current Health Problem	Treating Physician	Medication

Date of last physical examination: _____ **Physician:**_____

List previous care by a mental health professional:

Treating Practitioner	Dates	Family Member & Reason

Who referred you?

_____	Doctor / Psychiatrist	_____	Mental Health Professional
_____	School	_____	Court (Specify) _____
_____	Friend	_____	Employer
_____	Internet	_____	Attorney
			Name: _____

Briefly describe the reason for seeking help:

_____

_____

_____

_____

_____

_____

_____

_____

_____

What do you hope will change by participating in therapy?

_____

_____

_____

_____

_____