CONFIDENTIAL INTAKE INFORMATION

Gail Gabriel, MFT

YOUR NAME ________________________________
HOME ADDRESS ______________________________
CITY ___________________ STATE ____ ZIP _______
CLIENT'S BIRTHDATE _____________ AGE ______
TELEPHONE: HOME __________________________
TELEPHONE: CELL ___________________________
TELEPHONE: WORK __________________________
EMAIL ______________________________________

INSURED'S NAME _________________
INSURED'S BIRTHDATE ____________
INSURANCE ID# ___________________
INSURANCE PLAN _________________
GROUP/PLAN # ____________________
EMPLOYER _______________________
MARITAL STATUS _________________

SPOUSE/PARTNER'S NAME ____________________
HOME ADDRESS ______________________________
CITY ___________________ STATE ____ ZIP_______
SPOUSE BIRTHDATE _______________ AGE ______

PHONE: HOME ____________________
PHONE: CELL _____________________
PHONE: WORK ____________________
EMAIL ___________________________

CHILDREN (include stepchildren, his/initials, hers/initials, ours (O) and where they reside.)
NAME ____________________ BIRTHDATE________ ( ) SCHOOL___________ RESIDES _________
NAME ____________________ BIRTHDATE________ ( ) SCHOOL___________ RESIDES _________
NAME ____________________ BIRTHDATE________ ( ) SCHOOL___________ RESIDES _________
NAME ____________________ BIRTHDATE________ ( ) SCHOOL___________ RESIDES _________

PREVIOUS THERAPY _____YES _____NO   Reason for termination____________________________
If yes, when, how long and with whom? ____

PRESENTING PROBLEM: (Be as specific as possible including how it affects you and when it began.)
____
____

CUREENT GOALS FOR THERAPY: (Include what you hope to resolve or accomplish in therapy.)
____
____

MEDICAL HISTORY (Include most recent exam date, medications, & medical problems of family members.)
____
____
PRIMARY CARE MD________________________________   TELEPHONE __________________

PRESCRIPTION DRUGS:
WHO ___ TYPE _________________ AMOUNT _________ FREQUENCY _______ LAST TAKEN ______
WHO ___ TYPE _________________ AMOUNT _________ FREQUENCY _______ LAST TAKEN ______

DRUG OR ALCOHOL PROBLEMS: (all family members and AA, NA, treatment history.)__________ (Y/N)
____
ALCOHOL (#____drinks/day) (# ____ drinks/week) COFFEE (# ____ cups/day) CIGARETTES (#____ /day)
STREET DRUGS (who and what ____
FAMILY HISTORY: DOMESTIC VIOLENCE _____ (Y/N) SUICIDE _____ (Y/N) TRAUMA _____ (Y/N)

Please add any other information you think is significant for me to know in our work together on the back.