

Intake Form

Please complete this form prior to your first visit with
Jane Rodich, LMFT



CLIENT DEMOGRAPHICS:

Name: _____

Address: _____

City/State/Zip: _____

May I send correspondence to this address? Yes No

Cell Phone: _____

May I leave a message on this phone? Yes No

Email Address: _____

May I send correspondence to this address? Yes No

Marital Status (check one):

Married
Divorced
Single
Widowed
Separated
Living Together

Emergency Contact: Name: _____ Phone: _____

Birthdate: _____

Education Level (check one):

K-8th
High school
Some college/technical school
4-year degree
Graduate degree

PRESENTING PROBLEM:

Reason for seeking therapy: _____

When did this problem begin? _____

What changes do you want to happen as a result of counseling? _____

Have you previously worked with a psychotherapist? Yes No

Name of Therapist(s): _____

When did you receive counseling? _____

Are you under a physician's care? Yes No

Name of Doctor(s): _____

Current medications: _____

Current physical health (1=Poor, 10=Excellent) _____

Active life stressors (Check all that apply):

A vertical column of 18 empty rectangular boxes for checking off stressors.

- Death of spouse/close relative/friend
- Loss of job
- Change of job
- Divorce/custody/visitation
- Change in financial status
- Work-related difficulties
- Illness/chronic pain
- Illness of family member/close friend
- Retirement
- Child protection investigation/placement
- Addiction
- Sexual difficulties
- Court appearance/jail term
- Adoption
- Pregnancy/Miscarriage/Abortion
- Move to new residence
- Child leaving or returning home
- Other: _____

FAMILY BACKGROUND

Number of siblings: _____

Birth order:

Oldest
Middle
Youngest

Moved during childhood _____ times

Living situation during childhood/adolescence:

Raised with both parents - parents married
 Raised with both parents - parents not married
 Parents split, raised by mother
 Parents split, raised by father
 Parents split, raised by both parents
 Raised in foster/adoptive homes
 Other

Mother's occupation: _____

Mother still alive? Yes No

Father's occupation: _____

Father still alive? Yes No

Parent's current marital status:

Married
 Divorced
 Widowed
 Separated
 Living together

WORK EXPERIENCE:

Current position:

Over the past 28 days, *how many hours of work* (not including planned vacation time) have you missed due to a problem with your physical or emotional health? _____ hours

Over the past 28 days, *how many hours of work* (not including planned vacation time) have you missed due to family or relationship problems? _____ hours

Over the past 28 days, *how many days* did you come to work late or leave work early? _____ days

Over the past 28 days, *how would you rate your overall productivity* compared to your maximum level? _____ % of maximum productivity

CURRENT FAMILY OR HOUSEHOLD DATA

Please complete for each member of your household:

Name	Relationship	Age	Gender (M or F?)

Please complete the following chart to the best of your ability:

	Client	Spouse	Father	Mother	Brother	Sister	Grand parents	Aunts	Uncles	Step-parent
Alcohol / Drugs										
Depression										
Mental illness										
Eating problem										
Legal problems										
Physically abusive										
Physically abused										
Sexually abusive										
Sexually abused										
Verbally abusive										
Verbally abused										
Emotionally abusive										
Emotionally abused										

