AMY-LYNN GERBER
Licensed Marriage & Family Therapist
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CLIENT INTAKE FORM

Intake Date:_____

Client Information

Name:_____ Date of birth:_____

Address_____
street city state zip

Social Security#: _____

	Preferred	Ok to leave message?
Home Phone:_____	☐	☐
Cell Phone: _____	☐	☐
Work Phone: _____	☐	☐

Email: _____

Employer_____ Type of Work _____

Highest Level of Education Completed: ☐ High School ☐ Associate Degree ☐ Bachelor Degree
☐ Masters ☐ Doctorate ☐ Other
_____

Relationship Status: ☐ Single ☐ Married ☐ Divorced

Number of Children Living w/ You: ____ Ages: _____

Number of Children Not Living w/ You: ____ Ages: _____

Number of Other People Living w/ You:____

Relationship to You + Ages: _____

_____

Emergency Contact: _____Phone: _____

Relationship to you: _____

How were you referred to me? _____

Medical History

Primary physician: _____Phone_____

Have you ever suffered a serious illness or injury? _____

_____

Do you have a chronic illness or chronic pain?_____

_____

Please list any medications that you are currently taking and the purpose of each one:_____

_____

Psychiatric History

Psychiatrist: _____Phone_____

Have you recently experienced a very stressful event? _____

_____

Have you received psychotherapy or counseling in the past? Yes □ No □

If yes: when, with who, and for what reason? _____

_____

Have you ever been hospitalized for mental/emotional/psychiatric reasons? Yes □ No □

If yes: when, where, and for what reason?_____

_____

Have you ever received help for alcohol or drug dependency? Yes □ No □

If yes: when, where, and for what substance?_____

_____

Please list any psychiatric medications (antidepressant, mood stabilizer, etc.) you are currently taking and the purpose of each one:_____

_____

Presenting Problems/Issues

Please circle any concerns that apply to you:

Depression	Alcohol or drug use	Communication problems
Financial concerns	Anxiety, nervousness	Family concerns
Conflicts, arguments	Homicidal feelings	Eating problems
Suicidal feelings	Abuse (physical, sexual)	Work, career concerns
Sleeping problems	Paranoid feelings	Harm to self
Lack of anger control	Stealing	Sexual problems

Please describe the problem or issue for which you are seeking therapy: _____

_____

_____

How long have you had this problem/issue? _____

_____

_____

Why are you seeking help for this problem/issue at this time? _____

_____

_____

What would you like to see happen as a result of therapy? _____

_____

_____

_____ _____

Client Signature Date