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INTAKE

Name _____ Date _____

Birthdate _____ Driver's license or Calif. ID# _____

Mailing Address _____

City & Zip Code _____ Okay to leave phone message? yes ___ no ___

Please circle preferred phone if any Home Phone _____ Work Phone
_____ Cell Phone _____

Email _____ May I email you? yes ___ no ___

Be aware - email and cell phones are not always confidential forms of communication.

Occupation _____

Employer _____

Name of person or organization responsible for fees if different from above

Couple Status Never married ___ Domestic Partnership ___ Married ___
 Separated ___ Divorced ___ Widowed ___ Other ___

Persons Living in Household (also use other side if you need more room)

Name	birthdate/age	M/F	Occupation	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How did you find me? (circle one)

referral friend/family member website NCAMHP yellow pages other _____

Referred by (if applicable) _____

Have you previously seen a therapist? no ___ yes ___

Name of therapist _____

Why did you stop therapy with this clinician? _____

May I contact, with your permission, contact your former therapist? yes ___ no ___

Are you currently taking medication? _____ Please list name of medicine, strength, number of pills, and how often taken

Name of physician or primary care provider _____

Address & Phone _____

INSURANCE INFORMATION FOR BILLING - SKIP TO NEXT SECTION IF SELF PAY

Do you have medical insurance that covers psychological services? Yes ___ No ___

Name of insurance company _____

Address _____

Subscriber's Name _____

Subscriber Insurance Number _____

Subscriber Social Security Number _____

Subscriber Date of Birth _____

I will also need a copy, front and back, of your insurance card.

Note that by signing the attached "Consent to Treatment" contract you are agreeing to pay for sessions if your insurance company or EAP refuses payment, and you are agreeing to pay for sessions after your insurance authorized sessions have reached your policy limits.

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

2. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

3. How many times per week do you generally exercise, and what kind?

4. Please list any difficulties you experience with your appetite or eating patterns.

5. Are you currently experiencing overwhelming sadness, grief, or depression?

no ____ yes ____ (circle if yes)

6. Are you currently experiencing any of the following? (please circle)

anxiety panic attacks phobias obsessions compulsions

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? no ____ yes ____

If yes, please describe _____

8. Do you drink alcohol more than once a week? no ____ yes ____

9. How often do you engage in recreational drug use? (please circle)

daily weekly monthly infrequently never

10. Are you currently in a romantic relationship? no ____ yes ____ On a scale of

1 - 10 (10 is perfect) how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

FAMILY MENTAL HEALTH HISTORY

In the section below please identify any family history of the following - if yes, indicate the family member's relationship to you in the space provided (e.g. father, grandmother, cousin, aunt, etc.)

	Circle		List Family Member(s)
ADHD	yes	no	_____
Alcohol/Substance Abuse	yes	no	_____
Anxiety	yes	no	_____
Bipolar Disorder	yes	no	_____
Depression	yes	no	_____
Domestic Violence	yes	no	_____
Eating Disorders	yes	no	_____
Obsessive Compulsive Behavior	yes	no	_____
Schizophrenia	yes	no	_____
Suicide Attempts	yes	no	_____
Victim of childhood sex abuse	yes	no	_____
Other			_____

ADDITIONAL INFORMATION

1. Are you currently employed? no ___ yes ___

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? no ___ yes ___

If yes, describe your faith or belief _____

3. What do you consider to be some of your strengths? _____

4. What do you consider to be some of your weaknesses? _____

5. What would you like to accomplish during your time in therapy? _____

6. Other relevant information _____

Please read and sign the "Information and Consent for Treatment" form which is our mutual contract. This must be signed to begin therapy. Thank you.