Sophie Levy, MA, LMFT#100618
310-621-7476
1137 2nd Street, Santa Monica, St#203,CA 90403

INTAKE FORM: ADULT INDIVIDUAL

Name: _____

Birth Date:_____

Ethnicity:

Address:

_____

City: _____

Zip Code: _____

Cell Phone: _____

Other Phone (work, home): _____

May I leave a message?

E-mail Address:

In case of emergency, contact:

Name (relationship to you)

Address

Phone Number

<u>Relationship & Family Information:</u>

Married_____ Domestic Partnership_____ Committed relationship_____
Single_____Separated/Divorced_____
Widowed_____

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Other
(describe)_____

Length of current relationship:

Describe the quality of this relationship:

Poor_____ Fair_____ Good_____ Excellent_____

Please list children (any
age):_____

Please list members of your household:

General Information:

Family and Mental Health History
Have you received any kind of mental health services before? If yes, describe including diagnosis given at the time:

Type_____

Clinician/Agency_____
_____

Has anyone in your family ever been given a mental health diagnosis? (Please list medication if family member is taking any)

Are you or have you ever taken medication? (Please list medication you are currently taking)

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Dates:

Have you ever experienced any of the following:

Depression_____ Anxiety_____
Panic Attacks_____
Eating Disorders_____ Trauma/Abuse_____
Substance abuse/dependency_____ Domestic violence_____ Insomnia_____ Suicidal thoughts/attempts_____

Please explain any conditions checked above (timeline is relevant)

Have you ever had thoughts of hurting yourself (please list any prior attempts with dates)? If so when?

General Health
Medical diagnoses or conditions in your history:

Medications:

Describe your current physical health:

Poor_____ Fair_____ Good_____ Excellent_____

How many alcoholic beverages per week? _____What kind of alcohol?_____ Do you engage in recreational drug use? _____ If yes, what drug(s) ?_____

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Has anyone in your family ever needed treatment for alcohol or drugs, if so please describe?

Employment/Education
Highest level of education:

Profession & Current employer:

Describe your professional life:
Unsatisfying____ Somewhat satisfying_____ Satisfying_____ Very satisfying___

Do you have a specific sexual orientation or gender identification you would like me to know about?

Reasons for seeking treatment
Please describe current challenges, stressors and reason for seeking therapy:

Please describe your goals and desired outcome for therapy: