GRETA ANGERT, M.S. LMFT

Individual Information - Intake Form

Please fill out this biographical information as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. Please print or write clearly and bring it with you to the first session.

Date: _____

Name: _____ Male/Female: _____

Preferred name to be called: _____

Date of birth: _____ Place of birth: _____ Age: _____

Address: _____

Telephone & Email: Home: _____ Cell: _____

Work: _____ Email: _____

Confidential/private messages can be left at (Phone #): _____

Person and phone number to call in case of emergency: _____

Referral source: _____

Presenting problem (be as specific as you can: when did it start, how does it affect you):

_____

_____

_____

Estimate the severity of above problem ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Current marital status: _____ ☐ Live with someone Name: _____ Years _____

Names/ages of others that live in your home: _____

Past and present marriage(s) - names, years together, and the nature of the relationship(s), i.e. friendly, distant, physically/emotionally abusive, loving, hostile: _____

_____

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Present spouse/partner Education: _____ Occupation: _____

Children/stepchildren/grandchildren - names, ages, and brief statement on your relationship with the person:

Parents/stepparents - names, ages (or year of death and cause of death), occupation, personality, how s/he treated you, brief statement about the relationship:

Father: _____

Mother: _____

Stepparents: _____

Siblings - names, ages (or year of death and cause of death), brief statement about the relationship:

Medical doctor(s) - names and phone number:

Primary Care/Pediatrician: _____

Ob/Gyn: _____

Psychiatrist: _____

Others: _____

Past/present medical care - major medical problems, surgeries, accidents, falls, illness, etc.:

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Specify medication you are presently taking and for what. Print clearly.

Past/present drug/alcohol use/abuse (AA, NA, treatments):

Suicide attempt(s) or violent behavior - describe your age, reason, circumstances, how, etc.:

Family medical history - describe any illness that runs in the family, e.g. cancer, epilepsy, etc.:

Friendships, community, and spirituality:

Past/present psychotherapy - name of therapist, address, phone number, estimated number of sessions, month and year(s) from beginning to end, individual/couple/family, initial reason for therapy, medication, brief description of the relationship and how helpful it was, how/why it ended, positive/negative thoughts on each therapist experience (use other side of page to add more information about psychotherapists if needed):

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Describe your childhood, in general - relationships with parents, siblings, others, school, neighborhood, relocations, deaths, major life stressors, any school/behavioral/problems, abusive or alcoholic parent:

If parents divorced, your age at the time: _____

If yes, describe how it affected you at the time: _____

Education history (High School, College w/major): _____

Highest grade/degree: _____ Type of degree: _____

Employer (former, if retired) _____ Job Title: _____

Estimate how many hours/day you spend online (e.g. Facebook, YouTube, internet gaming, browsing, etc.):

Facebook _____ YouTube _____ Gaming _____ Browsing _____ Other: _____

Family history of alcoholism, substance abuse, mental illness, or violence (including suicide, depression, anxiety, hospitalizations in mental institutions, abuse, etc.): _____

Are you involved in any current or pending civil or criminal litigation(s), lawsuit(s), divorce, or custody dispute(s)? If yes, please explain:

What gives you the most joy or pleasure in your life? _____

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What are your main worries or fears? _____

What are your most important hopes and dreams? _____

Please circle the symptoms that you are currently experiencing (if any):

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	FOR HOW LONG
Sadness/Depression	0	1	2	3	_____
Hopelessness	0	1	2	3	_____
Suicidal Thoughts	0	1	2	3	_____
Sleep Problems	0	1	2	3	_____
Change in Appetite	0	1	2	3	_____
Weight Change	0	1	2	3	_____
Inability to Concentrate	0	1	2	3	_____
Obsessive Thoughts	0	1	2	3	_____
Tension/Anxiety	0	1	2	3	_____
Memory Problems	0	1	2	3	_____
Compulsive Behaviors	0	1	2	3	_____
Hostility/Anger	0	1	2	3	_____
Acts of Violence	0	1	2	3	_____
Social Isolation	0	1	2	3	_____
Strange Thoughts	0	1	2	3	_____
Sexual Problems	0	1	2	3	_____
Phobias	0	1	2	3	_____
Other	0	1	2	3	_____

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Please add any additional information that you would like me to know: _____

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