

Bridge Counseling Group, MFC #39867
10940 Fair Oaks Blvd, Suite 100
Fair Oaks, CA 95628
Phone (916) 557-8881

Intake Form for Adult Psychotherapy

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Referred by: _____

Please indicate if messages can be left or mail sent to:

Home Phone: Yes No Work Phone: Yes No

Cell Phone: Yes No Home Address: Yes No

In case of emergency, please contact: _____ Phone: _____

Relationship: _____

Date of Birth: _____ Social Security No. _____ - _____ - _____

Age: _____ Marital Status: S M W Sep. Div. No. of Years Married: _____

Spouse's Name: _____

Children (names & ages):

Place of Employment: _____ Occupation: _____

Responsible Party information:

Name: _____ DOB/Age: _____ / _____

Affiliation? (spouse, parent, etc.) _____

Briefly describe why you are seeking therapy at this time.

Primary Care Physician: _____ Phone: _____

Do we have your permission to coordinate care with your Primary Care Physician? Yes

No Date of last physical examination: _____

Treating Psychiatrist: _____ Phone: _____

Current Medications	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Therapist: _____ Date of Service: _____

Issues addressed in therapy: _____

Do you have any medical conditions that you are being treated for? Yes No

If so, please explain: _____

If you have ever been hospitalized, please list when and for what reason (Please include pregnancy and abortion). _____

Have you ever experienced any trauma in your life? Yes No

If so, please briefly explain: _____

List five (5) things about yourself that you like: _____

List five (5) things about yourself that you would like to change: _____

What are your major strengths? _____

Have any anniversaries of importance or stressful events in your life occurred recently? Are any due to occur soon? _____

List any major problems or stressful events that other family members or close friends are currently dealing with: _____

What solutions or efforts have you tried to solve resolve the problems that bring you here?

Do you have any religious affiliation? Yes No If so, what denomination: _____

Are you practicing or non-practicing in your faith?

Family History

Relationship	Name	Living	Deceased	Age	If living, location
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Is there any family history of mental illness? Yes No

Are there issues with your family origin that you believe are influencing the quality of life today? If so, please describe:

Do you drink alcohol? Yes No

If so, how much beer, wine or hard liquor do you consume each week on the average?

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever felt annoyed by criticism about your drinking? Yes No

Have you ever felt guilty about your drinking? Yes No

Have you ever had a Driving Under the Influence arrest? Yes No Date: _____

Do you smoke cigarettes? Yes No How many packs per day? _____

Do you have any compulsive behaviors that you would like to address in therapy? If so, please list.

Do you have any other information that you feel is important for me to know?

Please check all issues that apply:

Depressed mood

Gender issues

Co-dependency

Eating disturbance

Alcohol/drug use

Sexual disturbance

Physical abuse

Sleep disturbance

Obsessive/Compulsive

Hallucinations

Sexual abuse

Substance abuse (past)

Low self-esteem

Aggressive behaviors

Substance abuse (present)

Phobias/fears

Suicidal thoughts

Other _____

Chronic pain

High stress

Avoidant behaviors

Social skills problems

Panic attacks

Relationship issues

Anger/temper

Low energy/fatigue