MICHELLE C. BRANCH, M. A., LMFT
ALLIANCE THERAPY & WELLNESS

Date: _____

CLIENT INTAKE FORM

FIRST NAME : LAST NAME:
HOME ADDRESS:
E-MAIL: CONTACT PHONE:
EMPLOYER: OCCUPATION:
BIRTH DATE:
RELATIONSHIP STATUS: _____SINGLE ____ MARRIED _____PARTNER ____WIDOWED
NAME:
LENGTH OF RELATIONSHIP: DATE OF MARRIAGE:
(IF) CHILDREN'S NAMES, SEX (M/F), & AGES:
EMERGENCY CONTACT: PHONE:
REFERRED BY:
PRIOR THERAPIST & DATE LAST SEEN:
MAJOR MEDICAL PROBLEMS/LIST MEDICATIONS CURRENTLY TAKING:

PROBLEM DESCRIPTION

PLEASE CIRCLE THE MOST SIGNIFICANT ONE(S):

FEELINGS: Helpless, Depressed, Shameful, Angry, Guilty, Hopeless, Lonely, Sad, Stressed, Unhappy, Anxious, Out of Control, Afraid, Numb, Inferiority Feeling, Mood Shifts

THOUGHTS: Confused, Racing, Unintelligent, Obsessive, Worthless, Distracted, Unmotivated, Disorganized, Unattractive, Paranoid, Unlovable, Suicidal, Sensitive, Homicidal

SYMPTOMS/BEHAVIORS: Eating Less, Acting Out, Marital Issues, Crying, Procrastinating, Acting Aggressively, Suicide Attempt (s), Finances, Disorganization, Conflicts, Poor Concentration, Impulsivity, Lacking Ambition/Goals, Poor Peer Relationships, Withdrawing, Irritability, Nightmares, Skipping Classes, Passivity, Worries about body image, Binge Drinking, Drug Use, Spiritual Problems, Injuring Self, Alcohol Use, Dating Concerns, Overeating, Compulsivity, Career/Major Choice, Recklessness, Sexual Problems

ANY HISTORY OF:_____ DOMESTIC VIOLENCE _____CHILD ABUSE_____TRAUMA

_____ DEPRESSION _____ANXIETY/PANIC ATTACKS _____EATING/FOOD ISSUES

BRIEFLY DESCRIBE:

PRESENTING PROBLEM: (WHY ARE YOU SEEKING ASSISTANCE?)

WHAT WOULD YOU LIKE TO ACCOMPLISH BY COMING TO THERAPY?