Mindy Baba, MFT | Licensed Marriage & Family Therapist
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CLIENT INTAKE INFORMATION

Today's Date _______________

Name of Client _____________________________________ Birthday _____________
Name of Client _____________________________________ Birthday _____________

Children's Names _______________________ Age ____ Living at Home (Y/N) _____
_______________________ Age ____ Living at Home (Y/N) _____
_______________________ Age ____ Living at Home (Y/N) _____
_______________________ Age ____ Living at Home (Y/N) _____

Home Address _________________________ City ______________ Zip ____________

Phone Number(s): Home _______________ Work _____________ Cell ____________

Is it OK to leave a message? _________

Email Address ______________________

Occupation ___________________________ Social Security Number _____________

Place of Employment ___________________ P/T or F/T Student? ________________

School _________________________________

What are your reasons for coming to counseling?
____
____

POSSIBLE AREAS TO BE COVERED IN THERAPY:

__ abortion
__ academic/school difficulties
__ alcohol/drug problems
__ anger/resentment
__ behavioral problems
__ body image
__ career issues
__ communication
__ children/parenting
__ depression/anxiety
__ eating disturbances
__ faith
__ grief/loss
__ hurts or conflict
__ infertility
__ in-law difficulties
__ marriage/partner problems
__ personal growth
__ prior trauma
__ recent traumatic experience
__ relationship struggles
__ self-image
__ sexual abuse
__ sexual difficulties/issues
__ sleep difficulties
__ stress
__ suicidal thoughts
__ unwanted pregnancy
__ other ____

Please describe any current medical problems that may be affecting your mental health.

____

Are you presently taking medication(s)? If so, what medication(s)? How often? Dosage?

____

Name of Physician _______________________ Phone ______________________

Have you ever participated in any type of counseling or therapy? ______________
If yes, when and with whom? ____

Referral Source (agency and/or individual) ________________________________

If needed and with your permission, are you willing to sign a Release of Information so that I might consult on your behalf with your previous therapist, medical doctor, or school? ____

Faith affiliation ____

Please provide a name of a person I should notify in case of an emergency.
Name____

Relationship to you ______________________ Phone _______________________

Address ________________________________ City _____________ Zip _________