Fremont Psychotherapy
Graciela M. Fix, LMFT (#47357)
39812 Mission Blvd., Suite 106
Fremont, CA 94539
P:510.585.3514 F:888.549.3566

CLIENT INTAKE FORM Date:_____

Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ ZIP:_____

Phone (circle best number to call); Check if ok to leave messages:
□ Home:_____ □ Cell:_____ □ Work :_____
Email:_____ May I e-mail you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact:_____ Phone Number:_____

Marital Status (please circle):
Single Married Divorced Separated Widowed Domestic Partnership
Number of previous marriages, if any:_____

Please list any children/age: _____
_____

Insurance
Name of medical insurance plan, if any:_____
Insurance Number:_____
Insurance Group: _____

Primary Insured Information
Name of Primary Insured:_____
Primary Insured person's Date of Birth: _____ Primary Insured Phone: _____
Address:_____
City: _____ State:_____ ZIP:_____

Employment information
Currently employed? □ Yes □ No
Employer's Name:_____
Job title:_____ Years at this job:_____

Education information
Highest level of education completed:_____

General Health
Last complete physical exam?_____
Do you have a primary care physician?_____
What medications do you currently take? _____
_____
List specific health problems that you are experiencing_____

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Previous counseling (if any): _____
Previous therapist/counselor:_____

Mental Health Information

1. What brings you to therapy? Be as specific as you can and rate if the problem is mild, moderate or severe.

_____

_____

_____

_____

2. Substance Use: please circle (present = in the past 2 weeks):

	Present		Past			Present		Past			Present		Past	
Tobacco	Y	N	Y	N	Alcohol	Y	N	Y	N	Cocaine	Y	N	Y	N
Caffeine	Y	N	Y	N	Amphetamines	Y	N	Y	N	Hallucinogens	Y	N	Y	N
PCP	Y	N	Y	N	Opiates	Y	N	Y	N	Marijuana	Y	N	Y	N
Sedatives	Y	N	Y	N										

3. In the past 3 months have you experienced significant symptoms of (please circle):

Aggression	Crying	Fear	Irritability	Self-destructive relationships
Anger	Denial	Flashbacks	Memory Problems	Self-harm behaviors
Anxiety	Depression	Guilt	Nightmares	Sexual acting out
Apathy	Difficulty concentrating	Harm or threat to others	Obsessive behavior	Somatic (Body) Complains
Avoidance	Disordered eating patterns	Hyperactivity	Panic	Other:
Behavior problem	Dissociation	Hyperarousal	Phobias	
Compulsive behavior	Emotional numbing	Insomnia/sleep problems	Self-blame	

4. Have you ever tried to hurt yourself? □ Yes □ No If yes, when?_____

Describe what happened_____

_____

5. Have you ever tried to hurt someone else? □ Yes □ No If yes, when?_____

Describe what happened_____

_____

6. Have you ever been hospitalized for psychiatric reasons? ? □ Yes □ No

If yes, where?_____

and what happened?_____

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7. Are you currently in a romantic relationship? □ Yes □ No If yes, for how long?

_____

How is the quality of your relationship? _____

_____

_____

_____

8. In general, how it your relationship with your children/step-children?_____

_____

_____

9. In general, how is your relationship with your parents and siblings?

_____

_____

_____

10. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Family Mental Health History
In the section below, identify if there is a family history of any of the following:

Alcohol/Substance Abuse: _____
Anxiety: _____
Depression: _____
Domestic Violence: _____
Eating Disorders: _____
Obesity: _____
Obsessive Compulsive Behavior:_____
Schizophrenia: _____
Suicide Attempts: _____

1. Do you consider yourself to be spiritual or religious? □ Yes □ No
If yes, describe your faith or belief: _____

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

_____

_____

_____

_____

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3. What are your main fears and concerns?

_____

_____

_____

_____

4. What are your most important hopes and dreams?

_____

_____

_____

_____