Teri Ehlers, LAMFT
Postpartum and Relationship Counseling, LLC
3200 N Dobson, St. D4, Chandler, AZ 85224

Intake Form

Client Name_____ **Age** _____ **DOB** _____ **Date**_____

Client Address:_____

Client Phone number:_____

Client email Address: _____

Presenting Problem: (What brought you in to therapy today? How long have you been experiencing this problem?)

_____

_____

Identifying Information/Current Living Situation: (Who do you live with?)

_____

_____

Current symptoms: (Check all that apply)

_____ Mood Fluctuations

_____ Anger and/or Irritability

_____ Fear and/or Anxiety

_____ Obsessions and/or Compulsions

_____ Depression and/or Sadness

_____ Harm to self or others

_____ Suicidal Thoughts/Gestures

_____ Low Self-esteem

_____ Grief/Loss

_____ Attention Deficits

_____ Sleep difficulties

_____ Helplessness and/or Hopelessness

_____ Family/Marital/Couples Conflict

_____ Identity Confusion

_____ Hyperactivity

_____ Social Anxiety

_____ Weight and/or Body Image Issues

_____ Eating Disorder or Disordered Eating

_____ Spiritual Distress

_____ Pre-Marital or Marriage Counseling requested

_____ Other symptoms or Difficulties

What are current stressors in your life? (What kinds of things in your life cause you to worry?)

_____

_____

How are you currently handling stress?

_____

_____

What are current strengths? (Personal strengths and/or support systems: friends, family, church etc.)

_____

_____

Physician and/or Psychiatric Providers: (When is the last time you have a medical physical exam?)

_____

_____

Please list all prescribed medications and dosage:

_____

_____

Developmental and Medical History: (Any significant events from childhood or currently?)

_____

_____

Mental Health History: (Have you had any previous counseling? If so, please describe)

_____

_____

Substance Use/Abuse: (What is your past/current substance use?)

_____

Family of Origin and Current Nuclear Family:

Birth Mother: _____

Birth Father: _____

Stepmother: _____

Stepfather: _____

Siblings: _____

Spouse/Significant Other _____

Children and Ages _____

Current Family Dynamic:

_____

_____

Family Mental Health and Medical History:

_____

_____

Family of Origin Issues: (What was your birth family like?)

_____

_____

Education and Employment History:

_____

_____

Sexual and Social History:

_____

_____

Trauma and/or Abuse: (Have you experienced anything that you consider to be traumatic or abusive?)

_____

_____

Recreation and Pleasurable Activities:

_____

_____

Spiritual and/or Religious History:

_____

_____

Self-perceived Weaknesses:

_____

_____

Cultural or Ethnic Influences: (Are there any cultural or ethnic factors that effect your life?)

_____

_____

Suicide, Homicide. Self-Harm History and Present Functioning:

_____

_____

Preliminary Therapeutic Goals: (List 3 or 4 things you would like to accomplish through therapy at this time?)

_____

_____

_____

_____

Is there anything additional that you would like to share?

_____

_____

_____ _____

Signature of Client (Parent or Guardian of Minor) Date

_____ _____

Signature of Therapist Date