

Pamela M. Hughes, M.S.

Licensed Marriage and Family Therapist # 51647

INTAKE FORM

NAME: _____ MALE/FEMALE: _____ DATE: _____

ADDRESS: _____

TELEPHONE: H : _____ W/OFF.: _____ D.O.B.: _____ Age: _____

HIGHEST GRADE/DEGREE: _____ REFERRAL BY: _____

PERSON AND NO. TO CALL IN EMERGENCY: _____

MARITAL STATUS: _____ Former/Present marriage(s) (years): _____

SPOUSE NAME: _____ AGE: _____ OCCUPATION: _____

CHILDREN/STEP/GRAND (names/ages) : _____

SIBLINGS (names/ages): _____

PARENTS/STEP-PARENT(S) (Ages or year of death): _____

OCCUPATION/POSITION: _____

INSURANCE INF.: _____

PRESENTING PROBLEM: _____

MEDICAL DOCTORS: _____ PHONE: _____ LAST EXAM: _____

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations, current medication):

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Therapist: _____ Dates: _____ to _____ Phone: _____ Address: _____

Initial reason: _____ Process and outcome: _____

2. Therapist: _____ Dates: _____ to _____ Phone: _____ Address: _____

Initial reason: _____ Process and outcome: _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA/etc.): _____

FAMILY HISTORY OF ALCOHOLISM, METAL ILLNESS, VIOLENCE, SUICIDE: _____

Use the space on the back of this form if you need to give further information.