Rebecca Toner, M.A., LMFT #48432

Licensed Marriage and Family Therapist
(530) 588-7440

Adult Intake Form

Please complete this form in legible handwriting and bring it to your first session.
The information you provide is protected as confidential information.

Name: _____ Preferred Name: _____
(First) (Middle Initial) (Last)
Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No
Cell/Other Phone: _____ May I leave a message and/or text? □Yes □No

Birth Date: _____ /_____ /_____ Age: ____
Gender Identity: □ Male □ Female □ Other:_____ □ Decline to State
Sexual Orientation: □ Heterosexual □ Gay □ Bisexual □ Other: _____ □ Decline to State
Racial/Ethnic Identity: _____ □ Decline to State
Language Preference: _____
Religious/Spiritual Beliefs: _____ □Not Applicable

Marital Status:
□Married □Divorced □Never Married □Separated □Domestic Partnership □Widowed

Please list any children and ages: _____

Briefly, what is the main concern for which you are seeking my assistance? (i.e., depression, anxiety, relationship, stress, parenting, etc.
_____
_____

Have you previously been in counseling before?
□ No □ Yes
If so, with whom? Was it helpful? Why or why not?
_____
_____

HEALTH AND SOCIAL INFORMATION:

1. How is your physical health at present? (please circle)
Very Good Good Satisfactory Unsatisfactory Poor
Please list any specific health problems you are currently experiencing:
_____
Please list any known allergies: _____
Name of Primary Care Physician: _____ Phone Number: _____
Would you like for me to be in contact with him/her regarding our sessions?
□Yes □Not necessary at this time

2. Are you currently taking any prescription ***non-psychiatric*** medication?
□ No □ Yes, please list:_____
Name of Prescribing Dr: _____ Phone Number: _____

3. Are you currently taking any prescription ***psychiatric*** medication?
□ No □ Yes, please list with dates prescribed: _____
Please list all previously prescribed *psychiatric* medication with dates: _____
_____
Name of Prescribing Dr: _____ Phone Number: _____
Would you like for me to be in contact with him/her regarding our sessions?
□Yes □Not necessary at this time
Have you been assigned a formal mental health diagnosis? Please list: _____
_____

4. How would you rate your current sleeping habits? (please circle)
Very Good Good Satisfactory Unsatisfactory Poor
Please list any specific sleep problems you are currently experiencing:
_____

5. How many times per week do you generally exercise? _____
What types of exercise to you participate in: _____

6. Please list any difficulties you experience with your appetite or eating patterns:
_____

7. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes, for approximately how long? _____

8. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes, when did you begin experiencing this? _____

9. Are you currently experiencing any chronic pain?
□ No □ Yes, please describe? _____

10. Have you ever thought about hurting yourself? □ No □ Yes, dates: _____
11. Have you ever tried to commit suicide? □ No □ Yes, dates: _____
12. Have you ever been hospitalized for psychiatric reasons? □ No □ Yes, dates: _____

13. Do you drink alcohol? □ No □ Yes, how many drinks per week?_____
14. Do you engage in recreational drug use? □Daily □Weekly □Monthly □Infrequently □Never

15. Are you currently in a romantic relationship? □ No □ Yes, for how long? _____
On a scale of 1-10 (10 being the best), how would you rate your relationship overall? _____
On a scale of 1-10 (10 being the best), how would you rate your physical intimacy? _____
On a scale of 1-10 (10 being the best), how would you rate your emotional intimacy? _____

16. 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. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandfather, aunt, etc.).

Please Circle (yes or no)	**List Family Member(s)**
Alcohol/Substance Abuse---Yes/No	_____
Anxiety---Yes/No	_____
Depression---Yes/No	_____
Domestic Violence---Yes/No	_____
Eating Disorders---Yes/No	_____
Obesity---Yes/No	_____
Obsessive Compulsive Behavior---Yes/No	_____
Schizophrenia---Yes/No	_____
Suicide Attempts---Yes/o	_____

ADDITIONAL INFORMATION:
1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation?
_____

2. Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

3. What do you consider to be some of your strengths?
_____
_____

4. What are some effective coping strategies that have worked for you?

_____
_____

5. What are some negative coping strategies you engage in?

_____
_____

6. What are some of your goals for therapy?

_____
_____
_____

Thank you for taking the time to fill out this questionnaire.

Rebecca Toner, LMFT