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Phone 619.288.6866
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CONFIDENTIAL INTAKE FORM

Welcome. I look forward to working with you. This form requests information about you and/or your family that will help me plan your care. If you have any questions please feel free to discuss them with me.

Please print and complete legibly.

General Information

Name: ________________________________ Social Security #: _______-_____- ________
Address: ______________________________ City: ____________State___ Zip: ________
Date of Birth: ____/____/____ Age: ________ Marital Status: _____________________
Children's Names and Ages: ____
Employer: _____________________________ Occupation: ________________________
Home/Cell: (_____) ____________________ Work Phone: ________________________

Medical Information

Date of last physical: _____/_____/_____
Were there any problems found in your last physical? Yes / No
If yes, please explain: ____
Primary physician's name: __________________ Phone: (_____) ___________________
Do you have health insurance? Yes / No If yes, please read the following page.
Are you currently taking any medications? Yes / No
If yes, what medications and how long have you been taking them? _______________
____

Areas of Concern: Please describe your reason(s) for seeking treatment at this time (include date the problem started):____
____
____

Was there an event that made these issues or problems surface? ___Y ___N If yes, please describe:
____
____

Do you have any specific goals for treatment? What result(s) do you expect from treatment?____
____
____

What do you consider to be your strengths?____
____

Please indicate & rate the severity (1-4) of the following issues or problems you would like to work on in treatment:

NO PROBLEM 1	MILD PROBLEM 2	MODERATE PROBLEM 3	SEVERE PROBLEM 4
____Anger/Temper	____Eating Disorder	____Motivation	____Headaches
____Depression	____Body Image	____Controlling stress	____Loss of loved one
____Problems at school/work	____Anxiety/Panic	____Lack of friends	____Loneliness
____Problems Coping	____Domestic Violence	____Financial Problems	____Legal matters
____Relationship Issues	____Concentration	____Sleep Problems	____Fears
____Shopping Addiction	____Chronic Illness	____ Energy	____Divorce/Separation
____Gambling Addiction	____Sexuality/Sexual issues	____Family conflict	____Behavioral problems
____Drug/alcohol Addiction	____Obsessive/Compulsive Behavior	____ADD/ADHD	____Low Self Esteem
____Sex/Porn Addiction	___Childhood Trauma	____Adult Trauma	____Parenting Issues

Any other issues not listed
____

Have you ever received therapy before today? Yes / No
If yes, what were your reasons for the previous counseling? ________________________________
____

Who referred you ? __________________________ May we thank them? Yes / No
Church affiliation (if applicable):______________

Your therapist may ____ may not ____ identify him/herself when he/she calls your work.
Your therapist may ____ may not ____ identify him/herself when he/she calls your home.
Your therapist may ____ may not ____ send you e-mail regarding upcoming seminars, workshops, and publications.

Your e-mail address: ____

CONSENT FOR TREATMENT:

I, ____, authorize and request that Creston Davis LMFT to carry out psychological examinations, diagnostic procedures, and/or treatment which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement.

I also acknowledge that I have been provided therapist's Disclosure Statement, have had an opportunity to read same, and hereby agree to the terms stated therein, all of which are expressly incorporated into this Consent for Treatment.

I have read and fully under this Consent for Treatment and I have filled out the above information to the best of my ability.

____

Patient (or Parent/Guardian) Name – Printed Date

____

Patient (or Parent/Guardian) Name – Signature Date

____

Patient (Minor) Name – Printed Date

____

Patient (or Parent/Guardian) Name – Signature Date