Megan Bearce, LMFT, LLC

INTAKE FORM

CLIENT INFORMATION

Name:_____

Date of Birth:_____ Age: _____ ❒ Male ❒ Female

Address:_____

Occupation: _____ Employer: _____

School (if student):_____

Phone (h): _____ Messages ok at home? ❒ Yes ❒ No

Phone (cell): _____ Messages ok on cell? ❒ Yes ❒ No

Phone (w):_____ Messages ok at work? ❒ Yes ❒ No

Email: _____ Emails ok? ❒ Yes ❒ No
(Note: I cannot guarantee the confidentiality of email.)

How did you find out about Megan Bearce, LMFT? _____

Religious Affiliation: _____

Ethnic/Cultural Heritage: _____

_____

MARITAL STATUS

❒ Single ❒ Married (legally) ❒ Divorced Total # of marriages:_____

❒ Cohabitating ❒ Divorce in process ❒ Separated ❒ Widowed Other:_____

Assessment of current relationship (if applicable): ❒ Good ❒ Fair ❒Poor

FAMILY INFORMATION

Relationship	Name	Age	Sex	Type(bio, step, etc.)	Living with you?
Parent	_____	_____	_____	_____	❒ Yes ❒ No
Parent	_____	_____	_____	_____	❒ Yes ❒ No

Spouse/SO_____ _____ _____ _____ ❒ Yes ❒ No

Children/ Siblings _____ _____ _____ _____ ❒ Yes ❒ No

_____ _____ _____ _____ ❒ Yes ❒ No

_____ _____ _____ _____ ❒ Yes ❒ No

_____ _____ _____ _____ ❒ Yes ❒ No

EDUCATION

Fill in all that apply: Years of education:_____ Currently enrolled: ❒ Yes ❒ No

_____High School grad/GED _____College

_____Vocational: _____Graduate School

Other training:_____

Special circumstances:_____

MILITARY

Military experience? ❒ Yes ❒ No Combat experience? ❒ Yes ❒ No

Where:_____ Branch:_____

Type of discharge:_____ Length of service:_____

Rank at discharge:_____

PERSONAL STRENGTHS

What do you do well and what activities do you enjoy? _____

_____

What personal qualities would others say you have?_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____

_____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No

Approximate Dates of Counseling: _____

For what reason? _____

What did you find **most helpful** in therapy? _____

_____

What did you find **least helpful** in therapy? _____

_____

Have you used psychiatric services? Yes No Was it helpful? Yes No
Please describe. _____

_____

Have you taken medication for a mental health concern? Yes No

Name of medication	Dates Taken	Helpful?(Y/N)

Do you have other medical concerns or previous hospitalizations? Please describe. _____

_____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past._____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you/your child/adolescent to have counseling? _____

_____

What would you like to see happen as a result of counseling? _____

What is most concerning right now? _____

Do you ever have thoughts about ending your life? Y N
If yes, have you made a previous attempt? Y N
If yes, do you have a current plan you are considering acting on? Y N

Are any of the spaces in your home unusable because of the amount of clutter in them? Y N
Do any of the members of your family have a problem with this?
_____
Are you the victim of or abuse or bullying in any of your current relationships? Y N

Please describe your area(s) of
strength:_____

FAMILY CONCERNS

Please check any family concerns that you are having.

❒ Fighting
❒ Feeling Distant
❒ Loss of fun
❒ Lack of honesty
❒ Physical fights
❒ Education problems
❒ Money
❒ Disagreeing about Relatives
❒ Disagreeing about Friends
❒ Alcohol Use
❒ Drug Use
❒ Infidelity (Couple)
❒ Other
❒ Other

Comments: _____

INDIVIDUAL CONCERNS

Please check any personal concerns that you are having:

❒ Sadness _____	❒ Crying _____
❒ Irritability _____	❒ Loss of pleasure _____
❒ Sleep problems _____	❒ Eating problems _____
❒ Hopelessness _____	❒ Guilt _____
❒ Mood swings _____	❒ Fear _____
❒ Nightmares _____	❒ Flashbacks _____
❒ Obsessions _____	❒ Anxiety _____
❒ Panic _____	❒ Suicidal thoughts _____
❒ Suicidal acts _____	❒ Hurting self _____
❒ Hurting others _____	❒ Anger/Rage _____
❒ Abuse (childhood) _____	❒ Abuse (adult) _____
❒ Distractible _____	❒ Hearing things _____
❒ Seeing things _____	❒ Loneliness _____
❒ Grief/loss _____	❒ Work issues _____
❒ Spirituality issues _____	❒ Alcohol Use _____
❒ Another's Alcohol Use _____	❒ Drug Use _____
❒ Another's Drug Use _____	❒ Other_____

Comments: _____

_____

ADDITIONAL INFORMATION

Is there anything else you would like to share: _____

_____

_____

_____ _____

Client Signature Date