Peggy Barrett

LMFT, OTR/L

# INTAKE FORM

Name: _____ Date: _____

Address: _____ Home phone: _____

Cell phone: _____

E-mail _____ Referred by _____

Age _____ Date of birth _____ Marital status _____

Educational level _____ Occupation _____

Names and ages of children:

_____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

Emergency contact information: _____

_____

What is the best way to be in touch with you? _____

What issues/concerns causes you to seek treatment? Please describe.

_____

_____

Do you have any specific goals with regard to your treatment?

_____

_____

**Psychological History:**

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Name of therapist address, telephone number(s) _____

Have you ever been hospitalized for mental or emotional problems? _____

Are you currently taking any prescription medications? _____

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long? _____

Have you ever attempted suicide? _____

When? _____

**Medical History**

Have you ever been diagnosed with a serious illness? Please describe

_____

_____

Do you have any medical conditions that may affect your mental health treatment?

_____

Please describe your overall health today.

_____

_____

Other Information

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.

_____

_____

_____

_____