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Personal Information and Intake Form

*Having this important information about you will help me to best serve you.
The information you provide here is held to the same standards of confidentiality as our therapy.*

Today's Date: ____/____/____

Name: _____
(Last) (First) (MI)

Your Birth Date: ____/____/____ Age: ____ Gender: Male Female Trans/non-binary

Address:

(Street and Number)

(City) (State) (Zip)

Preferred Phone: _____ May I leave a message? Yes No

Alternate Phone: _____ May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

*Please be aware that email may not be as secure as other communications.

Emergency Contact Person: Name _____ Phone: _____

Nature of relationship to you _____

Marital Status: Never Married Married Separated Divorced Widowed

Are you currently in a romantic relationship? Yes No

♦ If yes, for how long? _____

♦ If yes, on a scale of 1-10 (10=great), how would you rate the quality of your romantic relationship? _____

Do you have children? No Yes

♦ If yes, how many?: _____ Names/Ages: _____

What prompts you to seek therapy now?

What are your overall goals for therapy?

In the last year, have you experienced any significant life changes or stresses?

Have you had previous psychotherapy? No Yes

◆ If yes, why and when?

◆ Are you hopeful about your future? Yes No

Have you ever been hospitalized in a psychiatric facility? Yes No If Yes, when? _____

Are you currently taking prescribed psychiatric medications? (antidepressants or others) Yes No

◆ If Yes, please list names and doses: _____

◆ If No, have you been previously prescribed psychiatric medication? Yes No

◆ If Yes, please list names and approximate dates: _____

HEALTH INFORMATION AND RISK ASSESSMENTS

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If currently taking medications other than the psychiatric medications mentioned above, what are they?

Hours per night you normally sleep _____ Are you having any problems with your sleep? Yes No

◆ If yes, please comment: _____

Do you exercise regularly? No Yes Comment _____

Are you having any difficulty with appetite or eating habits? No Yes

◆ If yes, check where applicable: Eating less Eating more Binging Purging

Have you experienced significant weight change in the last 2 months? No Yes

Do you drink alcohol? No Yes

If yes, what is your frequency? rarely a few times a month a few times a week almost every day

How many drinks do you typically have when you do drink? 1-2 3 or more

How often do you engage in recreational drug use? Never Rarely Monthly Weekly Daily

♦ If you checked any box other than “Never,” which drugs do you use? _____

Are you aware of drug or alcohol problems in your family? If so, please describe briefly: _____

Are you having current suicidal thoughts? Frequently Sometimes Rarely Never

Have you recently done anything to hurt yourself? Yes No

Have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

♦ If you checked any box other than “never”, when did you have these thoughts?

♦ Did you ever act on these thoughts? Yes No

♦ Have ever been the victim of, or witness to, child abuse or domestic violence? Yes No

OCCUPATIONAL, FINANCIAL, EDUCATIONAL, & LEGAL INFORMATION:

Highest level of education and where: _____

Are you employed? No Yes

♦ If yes, who is your current employer/position? _____

♦ Are you happy at your current job (or school)? _____

Please list any work (or school) stressors, if any: _____

Do you have financial concerns? No Yes

♦ If yes, please explain: _____

Do you have any legal concerns? No Yes

♦ If yes, please explain: _____

Are you currently in the military? No Yes Previously? No Yes

FAMILY AND RELATIONSHIPS:

Are your parents: still together divorced/separated, when _____

Mother's age _____ Living? _____ If deceased, when? _____

Father's age _____ Living? _____ If deceased, when? _____

Please describe your relationship with your parents when you were growing up and now: _____

Number of siblings: _____

Brothers, names and ages: _____

Sisters, names and ages: _____

Do you have good family support? No Yes If yes, from whom? _____

Are you aware of mental health issues in your family? Please describe briefly _____

OTHER INFORMATION:

What role, if any, do religion and/or spirituality play in your life?

What do you do that brings you joy, or helps you to care for yourself?

Is there anything that I did not ask about here that would be important for me to know about you?

How did you learn about me?