Mariah McQueen, M.A.

Licensed Marriage & Family Therapist #120401

CLIENT INTAKE FORM

PERSONAL INFORMATION (CLIENT # 1):

Full name of person initiating therapy: _____

Name you prefer to be called:_____

Age: _____ Date of Birth:_____

Occupation: _____ Employer/School:_____

Phone: _____ Email: _____

Address: _____

Gender: _____ Sexual Orientation: _____

Pronouns: _____ Ethnicity: _____

Religious/Spiritual Affiliation: _____

Military History: _____

Education Level: _____ Source of Income: _____

CLIENT #2 (if applicable):

Full name: _____

Name you prefer to be called:_____

Age: _____ Date of Birth:_____ Relationship to above: _____

Occupation: _____ Employer/School: _____

Phone: _____ Email: _____

Address: _____

Gender: _____ Sexual Orientation: _____

Pronouns: _____ Ethnicity: _____

Religious/Spiritual Affiliation: _____

Military History: _____

Education Level: _____ Source of Income: _____

RELATIONSHIP & HOUSEHOLD INFORMATION

Relationship Status & Structure:

	Married		Remarried		Partnered		Single
	Single Parent		Divorced		Separated		Widow(er)
	Monogamous		ENM		Polyamorous		Other

If applicable, Spouse/Partner's Name(s): _____

Do you have children? Yes / No

If yes, names & ages _____

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Who lives in your home? _____

_____

Who is your current social support system? _____

_____

Does anyone around you (family, close friends, roommates, co-workers) have any severe medical conditions, mental health or substance use issues?

_____

_____

THERAPEUTIC & MEDICAL HISTORY

Have you ever seen a mental health professional (psychiatrist, psychologist, therapist or counselor)? Yes / No

If yes, when? _____

Please briefly describe the reasons: _____

_____

_____

Any medical issues doctors have diagnosed: _____

_____

_____

Chronic medical conditions: _____

Hospitalizations: _____

_____

Allergies: _____

Are you currently taking any medication? Yes / No

If yes, explain: _____

_____

Use of substances (alcohol, marijuana, tobacco, etc.)? _____

_____

Fertility/Pregnancy/Postpartum experience: _____

_____

_____

When was your last medical examination? Were any issues raised? _____

_____

Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Do you have medicare as your insurance provider? Yes / No

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WORKING TOGETHER

What brings you to therapy today? _____

_____

_____

_____

Current mental health symptoms/presenting issues?_____

_____

_____

_____

What are your personal/relational goals? What do you hope to gain from therapy? _____

_____

_____

Is there anything else you would like me to know? _____

_____

_____

_____

_____

How did you hear about me?_____

May I thank the source? Yes / No

EMERGENCY CONTACT INFORMATION (Must be different than Client #2)

Name: _____ Phone: _____

Address: _____

Relationship to you: _____

CONTACTING YOU

May your therapist leave a message for you at your stated phone number? Yes / No

Can your therapist contact you by text message to discuss scheduling and other like issues? Yes / No

Can your therapist contact you by email to discuss scheduling and other like issues? Yes / No

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CREDIT CARD AUTHORIZATION

I authorize MARIAH McQUEEN, LMFT to keep my signature on file and to charge my credit card account for recurring charges (on-going treatment) of $ _____ every session from _____ to _____.

I understand this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

Cardholder's Name _____

Billing Address _____

Credit Card Type _____ Account # _____

Exp. Date _____ V-Code _____

Signature: _____ Date: _____

Printed Name: _____

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