

Mariah McQueen, M.A.

Licensed Marriage & Family Therapist #120401

CLIENT INTAKE FORM

PERSONAL INFORMATION (CLIENT # 1):

Name of person initiating therapy: _____
Age: _____ Date of Birth: _____
Occupation: _____ Employer/School: _____
Phone: _____ Email: _____
Address: _____

CLIENT #2 (if applicable):

Name: _____
Age: _____ Date of Birth: _____ Relationship to above: _____
Occupation: _____ Employer/School: _____
Phone: _____ Email: _____
Address: _____

Gender: _____ Sexual Orientation: _____
Pronouns: _____
Ethnic Background: _____
Religious/Spiritual Affiliation: _____
Military History: _____
Education Level: _____ Source of Income: _____

FAMILY & HOUSEHOLD INFORMATION

Relationship Status:

<input type="checkbox"/>	Married	<input type="checkbox"/>	Remarried	<input type="checkbox"/>	Partnered	<input type="checkbox"/>	Single
<input type="checkbox"/>	Single Parent	<input type="checkbox"/>	Divorced	<input type="checkbox"/>	Separated	<input type="checkbox"/>	Widow(er)

If applicable, Spouse/Partner's Name: _____

Do you have children? Yes / No

If yes, names & ages _____

Who lives in your home? _____

Who is your current social support system? _____

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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: _____

WORKING TOGETHER

What brings you to therapy today?

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Current symptoms/presenting issues? _____

What are your personal 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?

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?

(Please Circle): Yes / No

Can your therapist contact you by email to discuss scheduling and other like

issues? (Please Circle): Yes / No

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.

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Cardholder's Name _____

Billing Address _____

Credit Card Type _____ Account # _____

Exp. Date _____ V-Code _____

Signature: _____ Date: _____

Printed Name: _____