INTAKE FORM	**KIM OLSON, MFT** INDIVIDUAL AND FAMILY THERAPY LICENSE# MFT 35572

This information is requested so that I may be most helpful to you. Please feel free to talk with me about any questions or concerns. All information is confidential.

Your Name	Date
Address	
Home Phone	Work Phone/Cell
Birth Date	Employer
Email Address	
Insurance (if any)	Insured's Date of Birth
Please describe your reason(s) for seeking psychotherapy now	
Who referred you?	
Have you ever been in psychotherapy before? If yes, with whom and for now long?	
Please list who presently lives in your home, and their age and relationship to you	

Name	Age	Relationship

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PERTINENT HISTORY
Please describe any significant changes in your life recently (e.g. separation, divorce, deaths, changes in jobs, schools, friends, homes, etc.)
How do you get along with your brothers and/or sisters (if applicable)?
How do you get along with your friends/peers?
Are you currently married/dating? If yes, please describe your relationship with your partner
How do you get along with your parents?
Have you ever experienced any type of traumatic event (e.g. physical, sexual, or emotional abuse, rape, divorce, loss of significant other)? If yes, please describe
Have you had any changes in your eating habits? If yes, please describe
Have you noticed any changes in your mood? If yes, please describe
Have you felt like you didn’t want to live anymore? If yes, please describe

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Do you have any of these?

[ ] Laxatives [ ] Diet pills [ ] Self-induced vomiting

[ ] Alcohol [ ] Cigarettes

SCHOOL/EMPLOYMENT HISTORY	
Highest level of education/grade	Do/did you experience any struggles academically?
Are you currently employed?	Occupation
Do you have any hobbies/extracurricular activities?	

PERTINENT MEDICAL HISTORY	
Who is your primary care physician?	Please provide approximate date of last visit
Do you have any medical problems you are currently experiencing? If yes, please describe	
Are you presently taking any medications? If yes, please state the name and dosage of medications	
What is your current weight?	How tall are you?
Are you currently thinking about dieting or trying to lose weight?	

FOR WOMEN	
Have you started your period?	If yes, is it regular?
	If no, has it stopped?

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Are you sexually active?	Do you use birth control?
Do you exercise regularly? If yes, please describe	
Please describe any significant illness you may have experienced	
Do you have a family history of (please check all that apply)? [ ] Depression [ ] Alcohol/Drug Problem [ ] Overweight [ ] Underweight [ ] Anxiety/Panic Attacks [ ] Psychiatric Hospitalizations	
Is there anything I didn't ask that you would like me to know?	

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