Intake Form
Mark Glover, MA, LMFT
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The information you provide here is protected as confidential information.

TODAY'S DATE: _____

YOUR INFORMATION

Name: (print) _____Date of Birth: _____ Age: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone Contact # _____ (cell, home, or work)

Preferred Email Address: _____

Marital Status: ___Single __ Married __ Widowed __ Divorced __ Separated __ other

Occupation: _____

Emergency Contact Person: Name: _____ Contact info: _____

How did you hear about my practice? _____

PREVIOUS THERAPY:

Focus of any previous therapy _____

Was it helpful? _____

Why or why not: _____

_____

_____

Past Mental Health Diagnosis: _____

_____

Medications I currently take, the dose, and for what reason:

1) _____ dose _____ for _____
2) _____ dose _____ for _____
3) _____ dose _____ for _____

Write 3 positive adjectives to describe your Mother: _____

Write 3 negative adjectives to describe your Mother: _____

Write 3 positive adjectives to describe your Father: _____

Write 3 negative adjectives to describe your Father: _____

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Name _____ Date _____

ITEMS OF CONCERN:

___ Marriage or primary relationship
___ Gambling
___ Financial
___ Porn use (internet or other)
___Grief/loss
___ Low self-esteem
___ Job/career
___ Spending
___ Sleep
___ Eating
___ Spirituality
___ Discernment Counseling
___ Alcohol/drug use
___ Sex/sexuality
___ Mood
___ Self –harm
___ Extended family issues
___Other

Please check any symptoms you are currently experiencing or are concerned about, and note how long they have been troubling you:

___ Anxiety
___ Excessive worry
___ Nervousness
___ Excessive fears
___ Tension
___ Panicky feelings
___ Obsessive thoughts
___ Compulsive behavior
___ Feeling numb
___ Feeling disassociated
___ Feeling unreal
___ Difficulty concentrating
___ Irritability
___ Agitation
___ Depressed mood
___ Sadness
___ Fatigue/low energy
___ Crying more than usual
___ Loss of interest in activities
___ Trouble sleeping
___ Suicidal thoughts
___ Suicidal plan
___ Guilt/shame feelings
___ Perfectionism
___ Intrusive thoughts
___ Feelings of worthlessness
___ Feelings of hopelessness
___Serious physical illness- self or family
___Health concerns- self or family
___Death of family member or friend
___Reluctant to leave home/neighborhood
___Concern about dishonesty with others
___Mood swings
___Loss of temper/anger outbursts
___Aggressive/violent behaviors
___Physical abuse by others: current or past
___Physical abuse of others: current or past
___Sexual abuse by others
___Sexual abuse of others – current or past
___Recurrent flashbacks
___Episodes of lost time, unexplainable actions
___Confusion
___Much fantasy or daydreaming
___Hyperactivity/stomach aches
___Sexual concerns: decrease/increase in sexual activity
___Sexual identity concerns
___Identity concerns
___Feelings of unreality
___Unusual thoughts or perceptions
___Excessive energy
___Impulsive decisions or actions
___Difficulty trusting others
___Avoidance of conflict
___Withdrawn, isolating behaviors
___Shy/uneasy around others
___Fear of failure
___Fear of disapproval
___Need to please others and to be liked
___Difficulty saying no or asserting self
___Difficulty making independent decisions
___ Other not mentioned above:
_____
_____

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In your own words, what are the most important problems/issues you are experiencing at this time?

What are your expected/hopeful goals for the session? How do you want your life to be specifically?

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INFORMED CONSENT FOR EVALUATION AND TREATMENT

I acknowledge that I have read the policy of INFORMED CONSENT and CONFIDENTIALITY agreement and that I enter into therapy in agreement with this policy

Your signature below indicates that you have read and received a copy of the following and that you agree to abide by their terms during our professional relationship:

INFORMATION FOR CLIENTS

INFORMED CONSENT FOR THERAPY

CONFIDENTIALITY CONTRACT FOR MARITAL OR COUPLE THERAPY

THE CLIENT BILL OF RIGHTS

Name: _____ Date_____
(Please Print)

Signature: _____