



Tiffany McPherson, LCSW
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Intake Form

Generalized Information:

Name:			
SS #	Age	DOB:	
Address:			
Telephone number(s)	Home:	Work:	Cell:
Can I leave a message at this number?	YES/ NO	YES/ NO	YES/ NO
Preferred way to be contacted (circle choice):	Home	Work	Cell
May you be contacted by Email? YES / NO		Email:	

In case of emergency, who may I contact on your behalf?	Name:
Phone number:	Relationship:

If you have been previously married, please fill out the following section:

	Date began:	Date ended:	Ex spouse name	Children
1st Marriage				YES / NO
2nd Marriage				YES / NO
3rd Marriage				YES/ NO

Children: (list all children, including biological, adopted, foster, and step children)

Name	Age	Relationship	City, State	Lives at home?
				YES/ NO
				YES/ NO
				YES/ NO
				YES/ NO
				YES/ NO

Marital/ Partner/ Relationship Status (circle all that apply):

Single	Married	Divorced	Separated
Widowed	Remarried	Long-term relationship	Cohabiting

Current partner's name	Partner's occupation:	Length of relationship:
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How satisfied are you with your current relationship (on a scale from 1-10)?

(very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)



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What is your occupation?	Employer:
Do you enjoy your occupation? YES / NO	Average hour worked per/week

Highest level of education:	High school	Some college	College degree	Graduate School	Other
If you received a college/graduate degree, what was your degree in?					
If you are currently in school, what are you studying?					

How would you describe your spiritual or religious beliefs?
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Have you ever received or given abuse? YES/ NO	If yes please circle type: Physical Emotional Sexual Neglect Other
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Do you have a primary care physician? YES / NO	Physicians name:
Are you under the care of a psychiatrist? YES/ NO	Psychiatrist name:

Are under the care of specialist? YES/ NO					
If yes, please circle specialist(s) which provide you care:					
Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility Specialist	Nephrologist
Neurologist	Nutritionist	Occupational therapist	Oncologist/ Hematologist	Orthopedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:

Please list any chronic illness, disabilities, medical conditions that you have been diagnosed with:	
Illness/Disability	Dates

List all medications you are currently taking, including those you seldom use or take only as needed		
Medication	Dosage	Treating
Are you taking the medications according to your doctor's recommendation? YES/ NO	If no, briefly explain:	



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Average number of hours you sleep a night? _____ hrs	How long does it take you to fall asleep? _____ min. _____ hrs.
Do you wake up in the night? YES / NO	If yes, how often _____ times per night
How would you rate your overall sleep at the present time? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	

Do you exercise on a regular basis? YES / NO	If yes, how often _____ times _____ frequency
If yes, please describe activity briefly:	

How would you rank your overall diet on a scale form 1-10? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
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Do you drink alcoholic beverages? YES/ NO	If yes how many alcoholic beverages do you drink _____ weekly _____ daily
Do you think you have a drinking problem? YES/ NO	Does anyone else think you have a drinking problem? YES/ NO

Do you smoke? YES/ NO	If yes how many cigarettes/packs a day does you smoke? _____ cig. _____ packs a day
If yes when did you start smoking? _____ age	Have you ever tried to quit? YES/ NO

Have you in the past or currently used abused, experimented with illegal drugs? YES/ NO	If yes, briefly describe:
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Have you ever attempted/ seriously contemplated suicide? YES/ NO
If yes, describe briefly and indicate dates:

Have you ever had a psychiatric hospitalization? YES/ NO
If yes describe briefly and indicate dates



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Therapy Experiences and Expectations:

Are you <i>currently</i> seeing another therapist? YES / NO			
If yes, who are you seeing?			
Have you ever been in therapy in the past YES/ NO			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	Location	Dates	Reason

Briefly describe your reason(s) for seeking help at this time:

What goals do you wish to accomplish during the therapy process?

Is there anything else you would think would be important for me to know about you or your family?

Who referred you? Did you find me on the web? If so, which site did you visit?