Leah Sue Weiss, LMFT

New Client Intake Form

Date:

Basic Information	
Name:	Phone:
Address:	Date of Birth:
Occupation:	Gender Identity:
Employer:	Sexual Orientation:
Medi-Cal ID #:	Marital Status:
Names of people living with you: (and ages if children)	

Presenting Issues
Please list 3 or more issues that are bothering you, that are part of your reason for coming today, and that you would like to better understand or change.
1. 2. 3.

Psychological History	
Have you ever had therapy before? ☐ Yes ☐ No	If yes, when and for how long?
	Name of treating therapist:
	What was the focus of treatment?

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Do you take any psychiatric medications? ☐ Yes ☐ No	If yes, what medications? Name of prescribing physician:
Have you ever been hospitalized for mental or emotional problems? ☐ Yes ☐ No	If yes, when and for how long? Why were you hospitalized?
Do you currently have, or have you ever had, an eating disorder or other problem with food? ☐ Yes ☐ No	If yes, please describe:
Have you ever suffered from depression? ☐ Yes ☐ No	If yes, when?
Have you ever suffered from anxiety? ☐ Yes ☐ No	If yes, when?
Have you ever attempted suicide? ☐ Yes ☐ No	If yes, when?
Are you currently having suicidal thoughts? ☐ Yes ☐ No	
Please describe your childhood in a few words:	
Were you ever subjected to: ☐ Verbal abuse ☐ Physical abuse ☐ Emotional abuse ☐ Sexual abuse	If yes, please describe:

Medical History

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Are you currently taking any prescription medications? ☐ Yes ☐ No	If yes, what medications?
Have you ever been diagnosed with a serious illness or had major surgery? ☐ Yes ☐ No	If yes, please describe:
Do you have any chronic medical conditions? ☐ Yes ☐ No	If yes, please describe:
Have you ever received substance abuse treatment? ☐ Yes ☐ No	If yes, where?
Do you drink alcohol? ☐ Yes ☐ No	If yes, how often?
Have you ever used illegal drugs? ☐ Recently ☐ Past ☐ Never	If yes, what drugs?
I sleep well: ☐ Always ☐ Most of the Time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never	
I eat well: ☐ Always ☐ Most of the Time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never	
I get enough exercise: ☐ Always ☐ Most of the Time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never	

Other Information
Please describe your spiritual identity or orientation:
Please describe your interests and hobbies:

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Please list 3 ways you would like your life to be different 1 year from now: 1 2 3
Is there anything else you would like me to know about you?

Emergency Contact

Name:	Relationship:	Phone Number:

Name:	Relationship:	Phone Number: