Sam Stevens, LMFT
3325 NE Wasco St.
Portland, OR 97232
Phone: 503-957-8797 Fax (503)546-0120

Intake Form

SamStevensMFT@comcast.net
www.SamStevensMFT.com

Please provide the following information for my records. Leave blank any question you would prefer not to answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself at least 15 minutes prior to your appointment to complete the form in the office.

Name: _____

First Last Middle Initial

Birth Date: _____ / _____ / _____ Age: _____ Gender: _____

Local Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Primary Phone: Home □ Cell □ (____)_____- May I leave a message? □ Yes □ No

Other _____: (____)_____- May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

* Please be aware that email is not confidential. I will use it only for scheduling purposes.

Emergency Contact information:

Name:_____ Relationship: _____

Phone Number: (____)_____

How did you find out about my services?:

□ Friend □ Another therapist/medical provider □ Online Therapy Directory

□ Blue Therapist Directory book

If from a directory or provider, which one: _____

May I thank them for referring you? □ Yes □ No

Are you **currently** receiving professional counseling, therapy elsewhere?

□ Yes □ No If yes, current provider's name: _____

Have you been in therapy before?

□ Yes □ No If yes, previous therapist's name: _____

Are you **currently** taking prescribed psychiatric medication (antidepressants or others)?

□ Yes □ No If yes, please list:

_____

Who prescribed it? _____

May I contact them? □ Yes □ No

Have you previously been prescribed psychiatric medication?

□ Yes □ No If yes, please list:

_____

Who is your primary care doctor? _____

May I contact them? □ Yes □ No

What are you seeking help for today and how is it affecting you?

What are your goals for therapy?

How are you dealing with this now?

Any additional information that would help me in understanding what you are dealing with:

CURRENT ISSUES

Please indicate which of the following issues/problems you are currently experiencing:

□ Depression
□ Sleep problems
□ Lack of friends
□ Stress
□ Suicidal thoughts □ attempt
□ Homicidal thoughts
□ Mood swings
□ Hallucinations
□ Anxiety
□ panic attacks
□ Body image problems
□ Eating disorder
□ Traumatic events
□ Victim of abuse (physical or sexual)
□ Grief/loss
□ Problems at work/school
□ Family conflict
□ Alcohol/substance abuse
□ Other:
_____

Have you had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?

□ Frequently □ Sometimes □ Rarely □ Never

In the PAST have you ever experienced**:**

□ Depression
□ Sleep problems
□ Lack of friends
□ Stress
□ Suicidal thoughts □ attempt
□ Homicidal thoughts
□ Mood swings
□ Hallucinations
□ Anxiety/
□ panic attacks
□ Alcohol/substance abuse
□ Body image problems
□ Eating disorder
□ Traumatic events
□ Victim of abuse (physical or sexual)
□ Grief/loss
□ Problems at work/school
□ Family conflict
□ Other:
_____
_____

In the last year, have you experienced any significant life changes or stressors?

_____

Your relationship status (more than one answer may apply)

□ Single/dating □ Committed Relationship □ Married □ Divorced □ Other _____

If in a relationship, how long have you been together? _____

On a scale of 1-10, how would you rate the quality of your current relationship?

1 2 3 4 5 6 7 8 9 10

Comments/concerns about the quality or frequency of your sexual life:

_____

HEALTH INFORMATION

How is your physical health at present?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

_____

Are you having any problems with your sleep? □ Yes □ No

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other_____

How many times per week do you exercise? _____ Approximately how long? _____

Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes: □ Eating less □ Eating more □ Binging □ Restricting

Do you regularly use alcohol? □ Yes □ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

OCCUPATIONAL/SCHOOL INFORMATION:

Are you currently □ Employed □ Student □ Homemaker □ Other_____

What kind of work do you do?

_____

Are you happy in your current position(s)?

_____

If you are currently a student, what are your school's name and current year/grade

_____

Please list any work /school/responsibility-related stressors, if any:

_____

_____

PERSONAL AND FAMILY HISTORY

Significant people in your life (e.g., Parents, children, girlfriends/boyfriends, brothers, sisters, grandparents, step-relatives, half-relatives)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□

Family Mental Health History:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?:

□ Depression	□ Schizophrenia	□ Learning Disabilities
□ Bipolar Disorder	□ Suicide Attempts	□ Alcohol/Substance Abuse
□ Anxiety Disorders	□ Trauma History	Other: _____
□ Panic Attacks	□ Eating Disorders	_____

Childhood:

Were there any special, unusual, or traumatic circumstances that affected you as a child?

□ Yes □ No

If yes, please describe: _____

_____

_____

Have you experienced child abuse? □ Yes □ No

If yes, which type(s)? □ Sexual □ Physical □ Verbal □ Emotional

If yes, were you the: □ Victim □ Perpetrator □ Witness

Other childhood issues: □ Neglect □ Inadequate nutrition

□ Other (please specify): _____

_____

Other significant information: _____

_____

ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____

_____

_____

_____