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New/Returning Client Intake

Today's date _____

Name (full) _____ Date of birth _____

Home Phone _____ Cell _____ Work _____

Home Address _____

Marital Status _____ How long have you been in your current relationship? _____

Ethnicity _____ How long have you lived in this country? _____

Spiritual affiliation _____ Education Level _____

Current occupation _____ Employer _____

Contact in case of emergency:

Name: _____

Address: _____

Phone: _____

Relationship: _____

Names and ages of household members:

_____ age _____ relationship _____

_____ age _____ relationship _____

_____ age _____ relationship _____

_____ age _____ relationship _____

Medical Health Provider/Insurance _____

Current medical problems for which you are being treated:

Current medications, dosage, and reasons for prescription:

Three main reasons for seeking mental health services at this time:

1. _____
2. _____
3. _____

Please check any that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Unusual thoughts | <input type="checkbox"/> Excessive checking, lists making, washing |
| <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Ready to explode | <input type="checkbox"/> Isolating yourself |
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Panicky feeling | <input type="checkbox"/> Thoughts of Suicide |
| <input type="checkbox"/> Bowel trouble | <input type="checkbox"/> Tremors or tics | <input type="checkbox"/> Can't get interested |
| <input type="checkbox"/> Choking feeling | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Can't make friends |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Nervous around strangers | <input type="checkbox"/> Can't keep friends |
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Fear of things one "shouldn't fear" | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Muscular aches | <input type="checkbox"/> Strange experiences | <input type="checkbox"/> Feel like crying |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Distrustful of others | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Conflict with family | <input type="checkbox"/> Feel worthless |
| <input type="checkbox"/> Loss/increase of appetite | <input type="checkbox"/> Thoughts of harming others | <input type="checkbox"/> Trouble with memory |
| <input type="checkbox"/> Feeling tense | <input type="checkbox"/> Self-inflicted wounds | <input type="checkbox"/> Fear of losing control |
| <input type="checkbox"/> Binge eating | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Bad smells others don't smell |
| <input type="checkbox"/> Problems with anger | <input type="checkbox"/> Intrusive thoughts | <input type="checkbox"/> Can't keep jobs |
| <input type="checkbox"/> Worried about alcohol/drugs | <input type="checkbox"/> Sleep trouble | <input type="checkbox"/> Can't make decisions |
| <input type="checkbox"/> Restricting food | | <input type="checkbox"/> Anxiety |

Please briefly explain checked items: _____

Previous therapy: (Who with, when, for what?):

Group therapy (When, what group, for what?)

Couples therapy? (Who with, when, for what, how long)?

Psychiatric hospitalizations, previous suicide attempts (When, why, how long?):

Strengths: _____

Whom may I thank for referring you? _____