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INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not 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 30 minutes prior to your appointment to complete the form in the office.

Name: _____
(Last, First, MI)

Name of parent/guardian (if you are a minor): _____
(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: _____ Gender: Male Female

Local Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () _____ - May we leave a msg? Yes No

Cell/Other Phone: () _____ - May we leave a msg? Yes No

Referred by: _____

Marital Status:
 Never Married Partnered Married Separated Divorced Widowed

Number of Children: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Yes No

Have you had previous psychotherapy? No Yes

If yes, with (Previous therapist's name) _____

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

Yes No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication? Yes No

If Yes, please list: _____

Health & Social Information

1. How is your physical health at present? (please circle)
Poor, Unsatisfactory, Satisfactory, Good, Very good

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

3. Are you having any problems with your sleep habits? No Yes

If yes, check where applicable:

- Sleeping too little Sleeping too much Poor quality sleep
 Disturbing dreams Other _____

4. How many times per week do you exercise? _____
Approximately how long each time? _____

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

If yes, check where applicable: Eating less Eating more Binging
 Restricting

6. Have you experienced significant weight change in the last 2 months? No Yes

7. Do you regularly use alcohol? No Yes

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

8. How often do you engage recreational drug use? Daily Weekly Monthly
 Rarely Never

9. Have you had suicidal thoughts recently?

Frequently Sometimes Rarely Never

Have you had them in the past?

Frequently Sometimes Rarely Never

10. Are you currently in a romantic relationship? No Yes

If yes, how long have you been in this relationship? _____

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

11. In the last year, have you experienced any significant life changes or stressors:

Have you ever experienced:

- Extreme depressed mood . . . yes/no
- Wild Mood Swings yes/no
- Rapid Speech yes/no
- Extreme Anxiety yes/no
- Panic Attacks yes/no
- Phobias yes/no
- Sleep Disturbances yes/no
- Hallucinations yes/no
- Unexplained losses of time . . .yes/no
- Unexplained memory lapses . . yes/no
- Alcohol/Substance Abuse . . . yes/no
- Frequent Body Complaints . . .yes/no
- Eating Disorder yes/no
- Body Image Problems yes/no
- Repetitive Thoughts (e.g., Obsessions) yes/no
- Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) yes/no
- Homicidal Thoughts yes/no
- Suicide Attempt yes/no

Occupational Information:

Are you currently employed? No Yes
If yes, who is your current employer/position? _____
If yes, are you happy at your current position? _____
Please list any work-related stressors, if any: _____

Religious/Spiritual Information:

Do you consider yourself to be religious? No Yes
If yes, what is your faith?
If no, do you consider yourself to be spiritual? No Yes

Family Mental Health History:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty of Family Members

- Depression yes/no
- Bipolar Disorder yes/no
- Anxiety Disorders yes/no
- Panic Attacks yes/no
- Schizophrenia yes/no
- Alcohol/Substance Abuse yes/no
- Eating Disorders yes/no
- Learning Disabilities yes/no
- Trauma History yes/no
- Suicide Attempts yes/no

Other Information:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?