Jerry Fihn, MA, MFT, CADC-II, CSAT
Licensed Marriage and Family Therapist
LMFT #53136

CONFIDENTIAL INTAKE FORM

NAME:_____MALE/FEMALE:____DATE:_____

ADDRESS:_____

TELEPHONE: H:_____CELL:_____WORK:_____

DATE & PLACE OF BIRTH:_____AGE:_____

PERSON & PHONE NUMBER TO CALL IN AN EMERGENCY:_____

REFERRED BY:_____

OCCUPATION:_____

EDUCATION:

HIGEST GRADE/DEGREE:_____TYPE OF DEGREE:_____

CURRENTLY IN SCHOOL: Y / N WHAT GRADE:_____

CURRENT LIVING STATUS:

MARRIED/SINGLE/LIVING W/ SOMEONE/DIVORCED/SEPARATED
[circle answers]

PRESENT/PAST MARRIAGE(S) YEARS TOGETHER (statement about nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, etc.)

_____

_____

_____

15951 Los Gatos Blvd. Suite 13, Los Gatos, CA 95032 / 3060 Valencia Ave. Suite 7, Aptos, CA 95003
408-566-3683 jerryf.mft@gmail.com

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PRESENT SPOUSE/PARTNER:

Education:_____

Occupation: _____

CHILDREN/GRANDCHILDREN: (names/ages; brief statement on your relationship with each.

_____

_____

_____

PARENTS/STEPARENTS (names/age; living/deceased; brief statement about your relationship with them; how were you treated?)

FATHER:_____

MOTHER: _____

STEPPARENTS:_____

SIBLINGS: (name/ages; living/deceased; brief statement about your relationship):

_____

_____

_____

MEDICAL DOCTOR/PSYCHIATRIST (contact info):_____

_____

CURRENT/PAST MEDICAL/PSYCHOLOGICAL ISSUES: _____

_____

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CURRENT/PAST MEDICATIONS (for what & dosage):_____

_____

_____

CURRENT/PAST DRUG/ALCOHOL USE/ABUSE:_____

_____

_____

CURRENT/PAST SEX/GAMBLING/SPENDING/EATING ISSUES:_____

_____

_____

CURRENT/PAST TREATMENTS FOR ANY OF THE ABOVE (AA, NA, SA, OA or other treatment modalities): _____

_____

FAMILY HISTORY OF DRUG/ALCOHOL USE/ABUSE;
SEXUAL/GAMBLING/SPENDING/EATING ISSUES:_____

_____

_____

FAMILY HISTORY OF MENTAL ILLNESS/SUICIDE ATTEMPTS: _____

_____

_____

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CURRENT ISSUES FOR WHICH YOU ARE SEEKING HELP:_____

_____

_____

_____

_____

Are you currently having thoughts of suicide? **Yes/No**
Have you ever had thoughts of suicide? **Yes/No**
If Yes, when? _____
Have you ever experienced physical abuse? **Yes/No**
Have you ever experienced sexual abuse? **Yes/No**
Do you have current legal problems? **Yes/No**
If Yes to any of the above please describe:_____

_____

_____

_____

PREVIOUS TREATMENT:

Have you ever received outpatient or inpatient psychiatric or psychological Treatment before? **Yes/No**

If Yes, please list treatment dates, name of professional, reason for treatment and outcome below:

_____

_____

_____

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_____

_____

_____

_____

I herby certify that all information listed above is true to the best of my knowledge. I also certify that I have not purposefully made any misleading statements or knowingly reported incorrect information.

SIGNED:_____Dated:_____

Referral information: How did you learn about my counseling services? _____

_____

May I contact that person solely to acknowledge this referral? **Yes/No**

Acknowledging your referral will mean that the referring entity will know that you are receiving counseling from me.

I hereby give you permission to contact my referral source; limited to a personal thank you to other mental health professionals or agencies only.

SIGNED:_____Dated:_____

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