Rev. Santa CanteWi Molina-Marshall – licsw, sep
2227 Bel Pre Road #174, Silver Spring, MD 20906.
www.hpbysanta.net | hpbysanta@gmail.com | 301-537-6091

Client Psychotherapy Intake Forms

Date:

Name:

Address:

Telephone No.: (H/C) (W)

Email:

Gender Race Sexual Orientation

Age: Date of Birth Place of Birth

Check as many as apply

☐ Committed Relationship ☐ Single ☐ Divorced ☐ Separated

Highest level of education attained:

Place of Employment: (Tenure & Title)

Do you enjoy your work? Is there anything stressful about your work?

Name of child/children:	Age:	Date of birth:

Do you consider yourself to be spiritual or religious, if yes, describe your faith or belief.

Have you ever been involved in therapy or any other type of counseling program? ◯ Yes ◯ No

If yes, when? Where?

Reasons:

Reasons for considering counseling at this time:

Were you referred to this counseling office? ◯ Yes ◯ No

If yes, by whom?Name:

Are you in treatment with another counselor presently? ◯ Yes ◯ No

If yes, by whom?Name: How long?

Have you ever been hospitalized for any mental health reason? ◯ Yes ◯ No

If yes, when? Where?

Reason:

Are you receiving medical treatment from a psychiatrist? ◯ Yes ◯ No

If yes, with whom? Name: Phone:

(Please be sure to complete and bring in in with you the consent form you will find under "forms" on the website).

How would you rate your current physical health? (Please select one)

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

Please list any specific health problems you are currently experiencing:

Are you presently under a physicians care for physical problems? ◯ Yes ◯ No

If yes, please list reasons and any medications:

Name of family physician: Phone:

How would you rate your sleeping habits? (Please select one)

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◉ Very Good

Please list the specific problems you are having, if any

How many times per week do you exercise?

List any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief or depression?
If yes, describe and include for how long?

Are you currently experiencing anxiety, panic attacks or have any
phobias? If yes, describe and include when you began to experience this.

Are you currently experiencing any chronic pain? If yes, describe

Do you struggle with any type of addiction (this includes food, alcohol, illegal drugs, prescription drugs, gambling and or sex) If so, please explain.

How frequently do you use these substances or engage in addictive behaviors?

Have you ever, or are you now being treated by any type addiction? ◯ Yes ◯ No

If yes, when? Where?

By whom? Length of treatment:

Have you experienced any form of trauma? (please include a listing of your experiences. Include, major falls, accidents, major surgeries, childhood or adult sexual abuse, neglect, physical/emotional abuse, and any other experiences you consider traumatic). Specifics are not expected. We can discuss these in person in a regulated way.

Are you currently in a relationship? If so, for how long and how would you rate it on a scale of 1-10 How supportive is your partner/spouse?

Describe intimacy relationship history, starting with the present.

What do you consider to be some of your weaknesses?

What do you consider to be some of your strengths?

What concerns/challenges are you experiencing at this time?

What would you like to accomplish from your time in therapy?

What resources do you have (internal and external) that help you feel a bit better?

Family Mental Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle,etc).

	Please Select	List Family Member
Alcohol/Substance Abuse	◯ Yes ◯ No	
Other addictions	◯ Yes ◯ No	
Depression	◯ Yes ◯ No	
Domestic Violence	◯ Yes ◯ No	
Eating Disorders	◯ Yes ◯ No	
Obesity	◯ Yes ◯ No	
Obsessive Compulsive Behavior	◯ Yes ◯ No	
Schizophrenia	◯ Yes ◯ No	
Suicide/Suicide Attempts	◯ Yes ◯ No	
Narcissistic Personality	◯ Yes ◯ No	

Please use this page to list any other information you deem important to share with me, that was not asked above.

Person to contact in case of an emergency:

Phone:

Email:

Relationship to you:

Address:

Client Signature

Date:

Thank you for taking the time to complete this form.
This will help me to serve you.