Megan Kovacevic, PLLC

Licensed Marriage and Family Therapist

Client Intake Form

Clients Name: _____ Todays date:_____

Partner's Name (if being seen as a couple): _____

Address, City: _____Zip:_____

Home phone: _____ Work phone: _____

Private email address: _____

May I leave messages for you at home? Yes / No May I leave messages for you at work? Yes / No

Gender: _____ Age: _____ Birth Date:_____ Marital Status_____

Religious/spiritual upbringing_____ Current practicing status_____

Others Living in Home (name, age, relationship): _____

_____

Highest Level of Education: _____ Occupation:_____

Client's Employer: (optional) _____

Emergency Contact: _____Relationship to client:_____ Phone: _____

Referred by / How did you hear about our services?_____

May I acknowledge our meeting to any referral source?_____

Have you received previous counseling and /or substance abuse treatment: yes/ no

lf Yes, Name & number of therapist/ Agency (optional): _____

Past Diagnoses? months / years in treatment: _____

Name & number of primary care physician or health practitioner: _____

Any current medical or mental health conditions being treated?_____

*Do we have your permission to discuss or receive treatment records and or to receive diagnostic records from your past or current therapist, psychiatrist, and/or physician and/ or to disclose or share our clinical information? Yes_____ No_____

Signature_____ Date_____

Personal & Family information

Ethnic identity & background_____ Current relationship status_____

My birth parents currently: married/ live together- separated- divorced- never lived together
one or both are deceased

Family of Origin [parents/ step parents, adoptive parents, siblings]

Name Relationship to you Age or deceased

_____
_____
_____
_____
_____
_____

Current Family & Household [partner/spouse, roommates, children]

Name Relationship to you Age or deceased

_____
_____
_____
_____
_____
_____
_____

Check all that apply: (History of)

Counseling_____ Alcohol dependence_____ Drug dependence_____

Chronic physical illness_____ Chronic mental illness_____ Depression _____

Anxiety_____ Eating Disorders_____ Domestic Violence_____

Sex Abuse and or incest_____ Psychiatric hospitalization_____Suicide Attempts_____

I have experienced an unwanted sexual experience: recently____ in the past_____:

sexual assault_____ assault___ date rape____ rape____ incest____

(check all that apply)

. I use alcohol: never_____ less than once/ week_____ more than once /week_____ daily_____

. I use drugs: never_____ less than once/ week_____more than once /week_____ daily_____

. I use tobacco: never_____less than once/ week_____ more than once /week_____ daily_____

. My sleep is:_____ hours a night
Frequent waking? (y/n) / Difficulty falling asleep?-(y/n) Staying asleep? _(y/n)

. I am dissatisfied with my personal appearance? (y/n)

. I have felt like or tried to hurt myself in the past___(y/n) I'm currently hurting myself (y/n)

. I have suffered a recent significant loss or death -(y/n)

. I have suffered a recent relationship ending -(y/n)

I have experienced:

-medical complications at birth (y/n)_____

-serious head injury (or knocked out) (y/n)_____

-past learning disability or attention deficit/ hyperactivity disorder (y/n)_____

-permanent disability (if checked yes, please describe) (y/n)_____

-legal difficulties (if checked yes, please describe-) (y/n)_____

Current Concern(s): (circle all that apply)

Anger Decreased Energy Impaired Judgment Depressed Mood Elevated Mood

Dissociative state Guilt Fear Hyperactivity Hallucinations: (auditory / visual)

Obsessions Panic attacks Memory loss Oppositional Paranoia Delusional

Appetite disturbance (weight loss/ gain) Worthlessness Withdrawn Binging Purging

Sleep disturbance Marital Conflict Increased sleep Family Conflict Decreased sleep

Physical fighting Learning disability Anxiety Grandiosity Compulsions Distractibility

Poor Concentration

Medical History:

Are you taking your medication as prescribed?

Please list medications, dosage and frequency:

_____

_____

Illnesses: current and history:

_____
_____
_____

Please state briefly your reasons for seeking services at this time:

_____
_____
_____

What do you think may be getting in the way of you resolving your current problems or concerns?

_____
_____
_____

What are a few of your current goals that you wish to achieve while participating in counseling and how do you currently believe you can best achieve those goals?

_____
_____
_____

How would you like things to be different after you have participated in counseling/ consultation?

_____
_____
_____

If you could wake up tomorrow with a different life or in a different situation, what would that life look like?

_____
_____
_____

Other information you think may be useful in our therapeutic relationship?

_____
_____
_____