



Therapy Intake Form

Name: _____ Phone number _____ ok to leave message Y__N__

Date of Birth: _____ Preferred pronouns _____ Sexual Identity _____

MRN: _____

Relationship Status: _____

Reason for visit: _____

Have you had therapy before? Y__N__

If yes when? _____

What was the outcome?

Have you ever used illicit substances? Y__N__ If yes please list

When was the last time you used alcohol or another drug? _____

Reason for your visit today (Presenting problem):

What do you want to accomplish with therapy?
