

Peggy Scaief, LICSW, LLC, BCD
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INTAKE HISTORY

CLIENT IDENTIFICATION:

Name: _____ 1st Appt Date: _____
Birth Date: _____ Age: _____ Sex: _____
Address: _____ City: _____ State/Zip: _____
(H) Phone _____ (W) _____ Cell: _____
Email address: _____ Marital Status: _____ Blended family? _____
Children-please list names, ages:

REFERRAL SOURCE:

How did you hear about this office? _____

PURPOSE OF THE CONSULTATION:

(Please give a brief summary of the main problems)

PLEASE STATE WHAT MOTIVATED YOU DECIDE TO SEEK THERAPY NOW?

WHAT DO YOU HOPE TO GAIN FROM THERAPY?

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PAST THERAPY HISTORY:

Please include contact with other professionals, how long ago, how long, and the outcome

MEDICAL HISTORY:

Current medical problems/medications: _____

Past medical problems/medications: _____

Hospitalizations (place, cause, date, outcome): _____

Have you ever been suicidal? Thoughts, plan, when _____

In patient psychiatric hospitalization-when, how long, diagnosis, outcome:

CURRENT LIFE STRESSES: include anything that is currently stressful for you:

FAMILY STRUCTURE- who do you currently live with, add other information as necessary:

SIGNIFICANT DEVELOPMENTAL EVENTS (include marriages, separation, divorces, deaths, traumatic events, physical/physical abuse):

Current Marital or Relational Situation/Satisfaction: _____

EDUCATIONAL HISTORY

Last grade completed: _____ How was school for you? _____

Area of interest/degrees: _____

Any academic problems? _____

Learning strengths: _____

Employment: Current job _____

Satisfied with job _____ Not satisfied _____

Any work-related problems? _____

Military History: _____

Ever Have Any Legal Problems? Please describe _____

Alcohol and Drug History:

Please describe alcohol and drugs taken past, present and how much:

