Abraham Aviles-Scott
Licensed Marriage & Family Therapist

Patient Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information Today's Date: _____

Name (Last, First, Middle Initial): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Alternate phone: _____

E-mail: _____ Alternate E-mail: _____

Please indicate the means by which you prefer to be contacted. You may check more than one:

☐ Phone ☐ Text ☐ E-mail ☐ Regular Mail

If you would prefer to be contacted at a phone number, e-mail, or address *other* than what is listed above, please provide that information here: _____

Date of Birth: _____ Age: _____

Gender

☐ Woman ☐ Man ☐ Transgender (☐ Transman ☐ Transwoman)

☐ Gender Nonconforming ☐ Other: _____

Orientation

☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Asexual

☐ Queer ☐ Questioning ☐ Other _____ ☐ Prefer not to answer

What type of services are you currently seeking?

☐ Individual therapy ☐ Marital/Couples therapy ☐ Family therapy

☐ Other (describe) _____ ☐ Unsure

Goals of Treatment

What compelled you to seek therapy at this time?

Describe your current concerns, issues, or problems that you hope to resolve:

What do you hope to gain from therapy?

Relationship Status

Are you presently married or in a relationship? ☐ Yes ☐ No

If yes, how would you describe your current level of satisfaction with the relationship?

Have you married previously? If yes, when?

Name of the individual whom you identify as your significant other:

If you are married, or in a relationship, rate your level of contentment/happiness/satisfaction in the relationship on a scale of 1 to 10 (Number 1 indicates a sense of being very or extremely happy and the number 10 indicates a sense of being extremely unhappy). Briefly explain the rating you give in the space provided:

On a scale of 1 to 10, describe your level of commitment to your relationship (Number 1 indicates a sense of being very committed and the number 10 indicates a sense of not feeling at all committed). Briefly explain the rating you give in the space provided:

Source of Income

☐ Employment ☐ Unemployment ☐ Spouse/Significant Other

☐ Social Security ☐ Short Term-Disability ☐ Other _____

Employment Status

☐ Working Full-Time ☐ Working Part-Time ☐ Retired ☐ On medical leave

☐ Unemployed and looking for work ☐ Not employed due to other reasons

☐ Full-Time Student ☐ Part-Time Student

Highest Level of Education

☐ Elementary ☐ Some High School ☐ High School Diploma/GED

☐ Some College (no degree) ☐ Technical/Trade School Graduate

☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree

☐ Professional Degree (MD, JD, etc.) ☐ Doctoral Degree (PhD, EdD, etc.)

Military History

☐ Currently on active duty ☐ Served in Military ☐ Never served

Number of weeks, months, or years served: _____

If you have served in the military were you ever deployed? ☐ Yes ☐ No

If yes, please describe any issues that arose for you during or after deployment:

Legal History

Have you been ordered by the court to participate in this therapy? ☐ Yes ☐ No

If yes, you may be required to supply supporting documentation such as a copy of the court order.

Are you currently involved in any kind of litigation or legal dispute? ☐ Yes ☐ No

If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):

Emergency Contact Information

Who you prefer me to contact in case of an emergency?

Name: _____ Relationship: _____

Phone number: _____ Email: _____

Referral Information

If you were referred, by whom? _____

Payment Information

I am a contracted provider with Carelon Behavioral Health (formerly Beacon Health Options), Cigna/Evernorth, CuraLinc EAP, Kaiser (requires authorization), Magellan (including Blue Shield of California), and Optum (including UnitedHealthCare, UMR, and Sutter Select).

Please indicate how you intend to pay for treatment.

☐ Cash ☐ Check ☐ Credit Card ☐ PayPal/Venmo ☐ Third-Party

If a third-party will be paying for your treatment, please provide the following information:

Name of the person or organization paying for your therapy: _____

Your Relationship to this person or organization: _____

Contact Information for this person or organization: _____

PREVIOUS Mental Health Treatment History

Have you previously participated in therapy? ☐ Yes ☐ No

If yes, please provide any information you would like to share, including provider(s) name(s), contact information, dates of service, and focus of treatment.

Have you ever been hospitalized because of a mental health disorder? ☐ Yes ☐ No

If yes, please complete the following information:

Was hospitalization voluntary or involuntary? ☐ Voluntary ☐ Involuntary

How long was your hospitalization? _____

Where were you hospitalized? _____

Course of treatment during hospitalization:

Please provide the name(s) of the provider(s) who treated you.

CURRENT Mental Health Treatment

Are you currently participating in therapy or counseling? ☐ Yes ☐ No

If yes, please provide the name(s) of your current providers, contact information, dates of treatment, and focus of treatment.

*** If you are currently receiving therapeutic services from another psychotherapist, it may be necessary for me to contact your current psychotherapist to coordinate care and avoid duplication of services. You may be required to sign an *"Authorization for Release of Confidential Information"* form which will be provided to you and maintained as part of your clinical record along with a copy of this patient intake form. Please initial to indicate that you understand this paragraph: _____**

If you are currently under the care of a psychiatrist, are you taking any prescribed psychiatric medication(s)? ☐ Yes ☐ No

If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects. For example: *"Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)."*

If you are currently under the care of a psychologist, have you participated in any psychological assessments or tests? ☐ Yes ☐ No

If you have participated in psychological testing, please list the type of test performed, the specific name of the test, and the date(s) the test(s) were administered. For example: *"Personality Test (Type), Minnesota Multiphasic Personality Inventory "MMPI-2" (Specific name of test), February 01, 2017 (Date test was administered)."*

***California Civil Code Section, 56.10 states that information may be disclosed to "providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient" without the patient's consent. By initialing, you acknowledge and understand that I may contact either your current or former mental health care and/or medical providers only to discuss issues relevant to your diagnosis and treatment without your consent. Initial: _____**

Medical Treatment Information

Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition?

☐ Yes ☐ No

If yes, please provide any information you would like to share, including medical condition(s), medication(s), provider(s) name(s), contact information, dates of service, and prognosis.

Trauma History

Have you been – or are you currently being – emotionally, physically, or sexually abused?

☐ Yes ☐ No ☐ Prefer not to answer

If yes, please provide any information you would like to share regarding the underlying circumstances.

Family of Origin Information

Were you adopted? ☐ Yes ☐ No If yes, at what age were you adopted? _____

If you were adopted, do you have a relationship with your birth mother and/or father? ☐ Yes ☐ No

Are any of your parents (biological or adopted) separated or remarried? ☐ Yes ☐ No

Are any of your parents (biological, adopted, and/or step) deceased? ☐ Yes ☐ No

What type of relationship do you/did you have with your parents (biological, adopted, or step)?

Do you have any siblings (biological, adopted, step, half)? ☐ Yes ☐ No How many? _____

Please provide any additional information you would like to share about parents, siblings, or childhood family experience.

Mental Health/Risk Assessment

Please identify if you have experienced any of the following and whether this is a past, current, or reoccurring issue:

☐ Suicidal Thoughts:

☐ Past ☐ Present ☐ Reoccurring

☐ Thoughts of wanting to intentionally harm myself:

☐ Past ☐ Present ☐ Reoccurring

☐ Thoughts of wanting to intentionally cause harm to someone else:

☐ Past ☐ Present ☐ Reoccurring

☐ Post-Traumatic Stress:

☐ Past ☐ Present ☐ Reoccurring

If you are currently experiencing thoughts of harming yourself or someone else, please answer the following questions:

How long have you had these thoughts? _____

How frequently do you have these thoughts? _____

Do you have a plan and/or the means to carry out the threat of harm to yourself or someone else?

Have you ever tried to harm yourself or anyone else in the past?

Is there anything that would stop, or prevent, you from harming yourself or someone else?

If nothing would prevent you from harming yourself or someone else, please identify how likely it is that you might actually harm yourself or someone else. ☐ Definitely likely ☐ Not at all likely

Alcohol/Substance Use History

To the best of your knowledge, does any family member(s) struggle or struggled with alcohol/substance abuse or addiction:

Do you, yourself, struggle or struggled with alcohol/substance abuse or addition: ☐ Yes ☐ No

Please indicate your current substance use status:

☐ No history of use ☐ Actively using alcohol or drugs ☐ In early full remission

☐ In early partial remission ☐ In sustained full remission ☐ In sustained partial remission

If you indicated that you have an alcohol/substance abuse or addiction history, please identify the types of treatment you have participated in, or are currently participating in.

☐ Outpatient treatment ☐ Inpatient treatment ☐ 12-Step Program

☐ Stopped using on my own ☐ Other Method: _____

Was the above treatment method effective? Please explain:

Please check and provide details about the type(s) of substances you are currently using.

☐ Opioid(s): Classification: _____ Length of use: _____ Frequency of use: _____

☐ Heroin: Length of use: _____ Frequency of use: _____

☐ Cigarettes/Tobacco: Length of use: _____ Frequency of use: _____

☐ Alcohol: Length of use: _____ Frequency of use: _____

☐ Amphetamines: Length of use: _____ Frequency of use: _____

☐ Barbiturates: Length of use: _____ Frequency of use: _____

☐ Cocaine: Length of use: _____ Frequency of use: _____

☐ Crack: Length of use: _____ Frequency of use: _____

☐ Hallucinogens: Length of use: _____ Frequency of use: _____

☐ Inhalants: Length of use: _____ Frequency of use: _____

☐ Marijuana: Length of use: _____ Frequency of use: _____

☐ Other: Length of use: _____ Frequency of use: _____

If you have indicated that you have used, or are currently using substances, please indicate what side effects and or consequences you experienced or are experiencing as a result of the use.

☐ Overdose ☐ Suicidal Impulse ☐ Depression ☐ Anxiety ☐ Blackouts

☐ Loss of control ☐ Medical conditions ☐ Other: _____

Spiritual/Cultural History

Do you identify with a particular religion, culture, or spiritual practice?

Do any religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues?

Additional Information

Please let me know about anything that was not addressed in this intake or anything that you would like me to know about you, your goals, your relationships, or any recent significant life events.

Patient's Signature: _____

Date: _____