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INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Name: _____

(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: _____ Gender: Male Female

Marital Status:

Never Married Partnered Married Separated Divorced Widowed

Number of Children: _____

Local Address:

(Street and Number)

(City) (State) (Zip)

Home Phone: () - May we leave a msg? Yes No

Cell/Other Phone: () - May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please be aware that email might not be confidential.

Referred by: _____

1. Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Yes No
2. Have you had previous psychotherapy? Yes No
If yes, previous therapists' name _____
3. Are you currently taking prescribed psychiatric medication (antidepressants or others) Yes No

If yes, please list medications: _____

If no, have you previously been prescribed psychiatric medications? Yes No

4. Have you ever been hospitalized for a psychiatric illness? Yes No

If yes, when and where? _____

HEALTH AND SOCIAL INFORMATION:

How is your physical health at present? (please check)

- Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, diabetes, hypertension etc)

3. Are you having any problems with your sleep habits? Yes No

If yes, check where appropriate

- Sleeping too little Sleeping too much Poor Quality Sleep
 Disturbing Dreams Other

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having difficulty with appetite or eating habits? Yes No

If yes, please check where appropriate

- Eating less Eating more Binging Restricting
 Purging

6. Have you experienced significant weight change in the last 2 months? Yes No

7. Do you regularly use alcohol? Yes No

In a typical month, how often do you have 4 or more drinks in a 24hr. period? _____

- 8.. How often do you engage in recreational drug use? Daily Weekly
 Monthly Rarely Never

9.. Have you had suicidal thoughts recently?

Frequently Sometimes Rarely Never

Have you had them in the past?

Frequently Sometimes Rarely Never

10.. Are you currently in a romantic relationship? Yes No

If yes, how long have you been in this relationship _____

11.. On a scale of 1 – 10, how would you rate the quality of your current relationship?

12.. In the last year, have you experienced any significant life changes or stressors?

13.. Have you ever experienced?

Extreme Depressed Mood Yes No

Wild Mood Swings Yes No

Rapid Speech Yes No

Extreme Anxiety Yes No

Panic Attacks Yes No

Phobias Yes No

Sleep Disturbances Yes No

Hallucinations Yes No

Unexplained losses of time Yes No

Unexplained memory lapses Yes No

Alcohol/Substance Abuse Yes No

Frequent Body Complaints Yes No

Eating Disorder Yes No

Body Image Problems Yes No

Repetitive Thoughts (e.g. obsessions) Yes No

Repetitive Behaviors (e.g. frequent hand-washing, frequent checking) Yes No

Homicidal Thoughts Yes No

Suicide Attempts Yes No

OCCUPATIONAL INFORMATION:

Are you currently employed? Yes No

If yes, who is your current employer

What position do you hold? _____

Are you happy in your current position? _____

Please list any work-related stressors _____

If unemployed, are you?

Full-time student Yes No

Part-time student Yes No

On Disability Yes No

Retired Yes No

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself religious? Yes No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes No

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member)

Difficulty with:		Family Member
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anxiety Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Panic Attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Alcohol/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Learning Disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Trauma History	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

OTHER INFORMATION:

What do you consider to be your strengths? _____

What do you like most about yourself? _____

What are effective coping strategies that you've learned? _____

What are your goals for therapy?
