

## INDIVIDUAL INTAKE FORM

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Date: \_\_\_\_\_

|   |  |
|---|--|
| Client Last Name:   | Email Address                                      |
| First Name:   | Birthdate: <span style="float: right;">Age:</span> |
| Address:<br>City: <span style="float: right;">Zip:</span>   | Legal Guardian Name: (if under 18)                 |
| Education:  | Gender: <span style="float: right;">M/F</span>     |
| Profession:   | Home Phone:  |
| Marital Status: <span style="float: right;">M/ S/D/W</span> | Cell Phone:  |
| Children: Y/N If yes, how old?                              | Emergency Contact:                                 |
| Referred By:  | Emergency Phone:                                   |
|   | Relationship to Client:                            |
|   |  |

|                                    |
|------------------------------------|
| <b>Presenting Problem/Concern:</b> |
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|                                    |
|                                    |
|                                    |

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|---|
| <b>Suicidality and Violence Assessment:</b>       |
| Suicidal History (date/method of attempts): _____ |
| _____   |

Current Risk for Suicide:     None         Low         Medium         High

Current Risk for Violence/Dangerousness  None     Low     Medium     High

**General and Mental Health Information**

How would you rate your current physical health?

Please list any specific health problems you are currently experiencing:

Poor     Unsatisfactory     Satisfactory     Good     Very good

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How would you rate  your current sleeping habits? (please circle)

Poor     Unsatisfactory     Satisfactory     Good     Very good

Please list any specific sleep problems you are currently experiencing:

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Are you currently taking any prescription medications?

| Medications                     | Dosage | Reason |
|---------------------------------|--------|--------|
| 1.                              |        |        |
| 2.                              |        |        |
| 3.                              |        |        |
| 4.                              |        |        |
| <b>Hospitalizations/Surgery</b> |        |        |

How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise to you participate in:

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Please list any difficulties you experience with your appetite or eating patterns

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Do you binge/purge?.  Yes  No

If so, how often? \_\_\_\_\_

Are you currently experiencing overwhelming sadness, grief or depression?

No  Yes

If yes, for approximately how long? \_\_\_\_\_

Are you currently experiencing anxiety, panic attacks or have any phobias?

No  Yes

If yes, when did you begin experiencing this?

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Are you currently experiencing any chronic pain?

No  Yes

If yes, please describe? \_\_\_\_\_

Do you drink alcohol more than once a week?  No  Yes

If yes, how often? \_\_\_\_\_

How often do you engage in recreational drug use?

Daily  Weekly  Monthly  Infrequently  Never

Please list any prescription and/or illegal drugs you are PRESENTLY taking that have not been prescribed by a doctor:

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Please list any prescription and/or illegal drugs you have taken in the PAST that have not been prescribed by a doctor:

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**Family Mental Health History:**

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, sister, grandmother, uncle, etc.).

Alcohol/Substance Abuse:  No  Yes \_\_\_\_\_

Anxiety:  No  Yes \_\_\_\_\_

Depression:  No  Yes \_\_\_\_\_

Domestic Violence:  No  Yes \_\_\_\_\_

Eating Disorders:  No  Yes \_\_\_\_\_

Obesity:  No  Yes \_\_\_\_\_

Obsessive Compulsive Behavior:  No  Yes \_\_\_\_\_

Schizophrenia:  No  Yes \_\_\_\_\_

Suicide Attempts:  No  Yes \_\_\_\_\_

**Family Background:**

Parents still living? Father ( )Yes ( )No      Mother: ( )Yes ( )No

Parents: ( )Married ( )Separated ( )Divorced ( )Never Married

Siblings (Names/Ages): \_\_\_\_\_

\_\_\_\_\_

**ADDITIONAL INFORMATION:**

With whom are you living?

\_\_\_\_\_

Have you been married before?

\_\_\_\_\_

Are you currently in a romantic relationship?  No  Yes

If yes, for how long?

\_\_\_\_\_

On a scale of 1-10, how would you rate your relationship?

\_\_\_\_\_

What significant life changes or stressful events have you experienced recently?

Explain if any

\_\_\_\_\_

\_\_\_\_\_

Are you currently employed?  No  Yes

If yes, what is your current employment situation:

\_\_\_\_\_

Do you enjoy your work? Is there anything stressful about your current work?

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**Do you consider yourself to be spiritual or religious?  No  Yes**

**If yes, describe your faith or belief:**

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**Previous Therapy Experiences:**

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**Reason (s):** \_\_\_\_\_

**Therapy Expectations:**

**What are you expecting to get from therapy?** \_\_\_\_\_

**Do you have any particular goals that you would like to see met in therapy?**

**Please Explain:** \_\_\_\_\_