Mary Jane DeWolf-Smith, RN, PHN, MA, LMFT
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Thank you for completing this form. Mail by US Postage to:
Mary Jane DeWolf-Smith, 5 Luzanne Circle, San Anselmo, CA 94960

ADULT TELETHERAPY INTAKE FORM

1. **YOUR NAME** ____ DATE OF BIRTH_____/____/_____
(First) (Middle Initial) (Last)
Gender: □ M □ F □ other ______________________
Status: □ Never Married □ Domestic Partner □ Married □ Separated □ Divorced □ Widowed
Languages: Primary ________________________ Secondary________________________

ADDRESS: Number________ Street ____ Apt _________

City:____ ZIP ______________

PHONES: **Cell** ( ) _______ - ________**Home** ( ) _____ -__________ **Work**( ) _____ - __________

EMAIL: ______________________________________

Check the best way to communicate with you in case of emergency or need to reschedule.
___Home ___Cell __ Work ___ email.

EMGERGENCY CONTACT: Name____

Phone Number:__________ ______________________________

3. **FAMILY/HOUSEHOLD MEMBERS.**

Name ______________________________Date of Birth __/____/___ Relationship:______________

Name ______________________________Date of Birth __/____/___ Relationship:______________

Name ______________________________Date of Birth __/____/___ Relationship:______________

Name ______________________________Date of Birth __/____/___ Relationship:______________

Name ______________________________Date of Birth __/____/___ Relationship:______________

Your Name:____-

5. **STRESSES/CHALLENGES:** What are a few reasons you OR your family member seeks therapy at this time?
____
____
____
____
____
____

6. **GOALS**: What would you like to accomplish during your time in therapy?
____
____
____
____
____

7. **PREVIOUS BEHAVIORAL HEALTH SERVICES**

Name(s) of previous therapist/(s):

________________________________ Phone number: ______ _____________ Dates: _________to _____

________________________________ Phone number: ______ _____________ Dates: _________to _____

________________________________ Phone number: ______ _____________ Dates: _________to _____

What was helpful about working with the therapist(s)? ____
____

What was least helpful in working with the therapist(s)?____
____

Your Name:____-

8**. CHANGES/ STRESSORS**: What significant life changes or stressful events have you experienced recently?

9. **STRENGTHS:** What do you consider to be some of your strengths?

10. **SUPPORT SYSTEMS:** What family, friendships, and/or activities do you find helpful in times of need?

11. **AFFILIATIONS:** Do you identify with particular spiritual or religious practice or affiliation? □ No □Yes (please describe)____

12. **THOUGHTS, ACTIONS, FEELINGS:** Describe what thoughts, actions feelings may be troubling you.

Your Name:_______________________________________-

13. **FINANCIAL/ HOUSING CONCERNS**: Please describe:

____

Are you currently employed? □ Yes □ No
Employer: ____ Hours/week ______
Role: _______________________________________
Do you enjoy your work? □ No □ Somewhat □ Usually □ Most of the time
What is most stressful about your current work? ____

HEALTH INFORMATION

1. Please rate your current physical health? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good
Please list any specific health problems you are currently experiencing including allergies:

____

Please list past health challenges and year of diagnosis:

____

____

2. When was your last physical examination with your health care provider? Month______ Year______

3. Name of Primary Care Provider: ____
Hospital/HMO:____

4. Are you currently experiencing any chronic pain? □ Yes □ No
If yes, please describe ____

5. How well are you sleeping? Average hours of sleep per night __________
□ Rarely Sleep □ Hard going to sleep □ Wake up / can't get back to sleep □ Nightmares

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

____

7. Are you currently experiencing overwhelming sadness, grief or depression? □ Yes □ No

If yes, for how long? _____ Are you having thoughts about ending your life? □ Yes □ No

8. Are you currently experiencing anxiety, PTSD, panic attacks, or phobias? □ Yes □ No
If yes, describe/explain your physical experience:____

____

____

When did you begin experiencing this? ____

____

Your Name:____-

9. What number of times per week do you exercise (including yoga)? □ none □2 days □ 3 days □ other _____
   Types of exercise: ____

10. What supplements (vitamins, minerals, herbs, tinctures) do you take? __________________________________
    ____

11. Have you ever been prescribed psychiatric medication? □ Yes □ No
    Please list psychiatric medications,, dosage, approximate dates taken, and check the box if they were helpful.
    ______________________________ dosage___________ dates_ ______ to ______ □ Yes □ No
    ______________________________ dosage___________ dates_ ______ to ______ □ Yes □ No
    ______________________________ dosage___________ dates_ ______ to ______ □ Yes □ No

12. Have you ever been hospitalized due to a mental health concern? □ Yes □ No
    Condition:____ Dates: ______to ______
    Describe:____

13. SUBSTANCE USE:
    How frequently do you drink alcohol? □ In recovery for ____ years □ Never □ Daily □ Weekly
    How many glasses of alcohol do you drink in one period of time? □ one □ two □ three □_____
    Has your drinking led to difficult consequences? □ Blackouts □DUI □ Work disruption □ Fights

    Do you smoke or inhale marijuana products? □ Yes □ No
    How frequently? Daily: □ one □ two □ three times or Weekly □ one □ two □ three times

    Have friends/family ever expressed concern for your alcohol or other drug use? □ Yes □ No

14. Do you use drugs or psychoactive substances not prescribed for you? □ Yes □ No
    If "Yes" how often? □ Infrequently □ Daily □ Weekly □ other ___________________________________
    Please list substances: ____

15. Other health information:
    Significant injuries, illnesses, and hospitalization:
    ____

    Chronic conditions:____
    ____

    FOR WOMEN: # __ pregnancies__ miscarriages __ terminations of pregnancy ___ births
    Difficult menstrual cycles ____
    Difficult pregnancies____
    Difficult births____
    Postpartum recovery challenges and/or depression____

    FOR MEN: __ urinary tract/ prostate difficulties ___ erectile dysfunction ___impotence

Your Name:____-

FAMILY HEALTH HISTORY

	Self	**Family**	Relationship
AD/HD	_________	_______	______________________________
Arthritis	_________	_______	______________________________
Alcohol/Substance Abuse	_________	_______	______________________________
Anxiety	_________	_______	______________________________
Autism Spectrum	_________	_______	______________________________
Bipolar Disorder	_________	_______	______________________________
Cancer	_________	_______	______________________________
Child Abuse	_________	_______	______________________________
Diabetes	_________	_______	______________________________
Depression	_________	_______	______________________________
Domestic Violence	_________	_______	______________________________
Eating Disorders	_________	_______	______________________________
High Blood Pressure	_________	_______	______________________________
Incarceration	_________	_______	______________________________
Learning Disabilities	_________	_______	______________________________
Obesity	_________	_______	______________________________
Obsessive Compulsive Behavior	_________	_______	______________________________
Panic Attacks/Phobias/PTSD	_________	_______	______________________________
Recent Death of Loved One	_________	_______	______________________________
Self-harm/cutting/picking	_________	_______	______________________________
Schizophrenia	_________	_______	______________________________
Suicide or Attempted Suicide	_________	_______	______________________________
Violent Death/Injury of Loved One	_________	_______	______________________________
Other Traumatic Events	_________	_______	_______________________________
5150 Hospitalization	_________	_______	______________________________

FAMILY MEMBERS **Cause of Death** **Year**

Mother's Name: __________________ DOB ___/___/_____ Living? □ Yes □ No ________________ ______

Father's Name: ____________________ DOB ___/___/_____ Living? □ Yes □ No _______________ ______

Name: _________________________ Age____ □ M □ F Living? □ Yes □ No ________________ ____

Name: _________________________ Age____ □ M □ F Living? □ Yes □ No ________________ ____

Name: _________________________ Age____ □ M □ F Living? □ Yes □ No ________________ ____

Name: _________________________ Age____ □ M □ F Living? □ Yes □ No ________________ ____

Please Send by US Mail to: Mary Jane DeWolf-Smith, LMFT; 5 Luzanne Circle, San Anselmo, CA 94960