Elizabeth
L. Ramírez, M.S., MFT

Today's Date: _____

INTAKE FORM

IDENTIFYING INFORMATION

Name _____ D.O.B. _____/_____/_____ Gender _____

Address _____

Primary Telephone _____ other _____

email address (*optional)*: _____

Ethnicity _____ Highest Education level _____

Current Employment:_____

Relationship status (*single, married, separated, etc)*: _____

Children:

Name age

_____

_____

_____

_____

_____

Other adults in home:

Name relationship time living in home

_____

_____

_____

Emergency Contact Name/Relation: _____ Phone: _____

Who referred you _____

Are you involved in any litigation (lawsuits, divorce, child custody, court proceedings, personal injury) or may be in the future? _____

COUNSELING GOAL: What do you want to get out of being here? How will we know when counseling goals are met?

_____

_____

HEALTH HISTORY (current physical health, health changes) Last physical/wellness visit:_____

_____

_____

Medication (past and/or current) _____

_____

_____

Prescribing Doctor: _____

ALCOHOL & DRUG USE (past, present use of alcohol/drugs/smoking, etc.)

_____

_____

PRESENTING CONCERNS: Please identify below any concerning symptoms:

Anger	Crying	Fearful	Low energy	Palpitations	Social issues
Anorexia	Delusions	Hallucinations	Low motivation	Panic attacks	Stomachaches
Anxiety	Depression	Headaches	Low self esteem	Relationship issues	Stress
Appetite changes	Domestic violence	Hyperactivity	Mood changes	School/work issues	Suicidal
Bowel Problems	Drug use	Insomnia	Nightmares	Self doubt	Tension trauma
Bulimia	Gender issues	Irritable	Obsessions	Sexual difficulties	Unfocused
Compulsions	Grieving	Isolation	Overeating	Sleep problems	

Clinical Notes/Initial Session (MSE):