Dagmara Svetcov, MS, LMFT
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INTAKE INFORMATION

Client Name:		Today's Date:	
Parent / Legal Guardian Name (if under 18 years old):		Referred by:	
Address:		DOB:	Age:
City:		ZIP:	
Email Address: ☐ OK to contact via email		Gender: _____	
Home Phone: _____ ☐ OK to leave message	Cell Phone: _____ ☐ OK to leave message	Other Phone: _____ ☐ OK to leave message	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:_____			

SCHOOL/EMPLOYMENT

Are you attending school?..... ☐ Yes ☐ No

If YES, what school? _____ If YES, what grade? _____

Are you employed?..... ☐ Yes ☐ No

If YES, what is your occupation? _____

If YES, who is your employer? _____

MEDICAL INFORMATION

Do you currently see a any health care provider (medical or wellness)? ..... ☐ Yes ☐ No

If YES, please explain:

_____

_____

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CURRENT MEDICATION

Name of Medication:	Dosage:	Prescribed by:

PREVIOUS COUNSELING HISTORY

Year:	Length:	Therapist Name:	Results:

REASON FOR REFERRAL:

Briefly state the specific problems that have led you to seek treatment at this time:

_____

_____

PRESENTING PROBLEMS

Please indicate and rate the severity (1 - 4) of any of the following issues or problems you would like to address in treatment:

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Physiological:

☐ Headaches	☐ Stomach problems	☐ Bowel Trouble
☐ Always Fatigued	☐ Eating / Appetite Problems	☐ Sleeping Problems
☐ Difficulty Relaxing	☐ Health Problems	☐ Other

Emotional:

☐ Irritability	☐ Tense Feelings	☐ Panic Attacks
☐ Fears / Phobias	☐ Sadness / Often Tearful	☐ Depressed
☐ Thoughts of Suicide	☐ Thoughts of Homicide	☐ Ready to Explode
☐ Anxious	☐ Anger Management	☐ Other

Compulsions:

☐ Internet Use	☐ Sexual Behaviors / Urges	☐ Spending / Shopping
☐ Excessive Use of Drugs / Alcohol	☐ Pornography	☐ Gambling
☐ Obsessive Thinking	☐ Other	

Other:

☐ Harmful Behavior	☐ Sexuality / Gender Issues	☐ Loneliness / Isolation
☐ Legal Problems	☐ Stress Management	☐ Domestic Violence
☐ Financial Problems	☐ Work / School Problems	☐ Grief / Loss Issues
☐ Exposure to Trauma	☐ Victim of Crime / Abuse	☐ Problems Coping
☐ Suicide Attempt in Past	☐ Past Hospitalization	☐ Family Conflict
☐ Marriage / Relationship Problems	☐ Indecisiveness	☐ Separation / Divorce
☐ Parenting	☐ Self-Esteem	

If OTHER, please explain:

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Is there anything else that is important for me, as your therapist, to know about?

_____

_____

Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. You may list more than one goal.

_____

_____

_____

REFERRAL SOURCE

☐ Self ☐ Other

☐ Friend

☐ Internet

If OTHER, please explain: _____

EMERGENCY CONTACT DETAILS

I give Dagmara Svetcov, LMFT permission to contact this person in case of emergency.

Contact Name:	Relationship:
Address:	Contact Phone:
Client Signature:	Date:

During our professional relationship, I might need to contact you via mail to discuss confidential information (appointments, billing, or other detailed information regarding your treatment).

To what address can we mail your *confidential information*? May we use the same address listed above?
☐ Yes ☐ No. If NO, please provide the address you would like us to use:

_____

_____