

Corrine McIntosh Sako, PsyD LMFT

Clinical Psychologist • PSY 31218

Licensed Marriage & Family Therapist • LMFT 43424

1300 Ethan Way, Suite 170 • Sacramento, CA 95825 • (916) 202-1890

INTAKE FORM

Please fill out completely

Date: _____

Who referred you to this office? _____

Name: _____ Date of Birth: _____ Age: _____

Address (not a p.o. box): _____

City: _____ Zip Code: _____ County: _____

Home Telephone Number: (____) _____ Cell: (____) _____

Email address: _____

What is your current gender identity? (Check ALL that apply)

- Male Female Transgender Male/Transman/FTM
- Transgender Female/Transwoman/MTF Gender Queer
- Additional category (please specify): _____
- Decline to answer

What sex were you assigned at birth? (Check one)

- Male Female Other Decline to answer

What pronouns do you prefer that I use when talking about you? (check all that apply)

- She/her/hers He/him/his They/them/theirs
- Other: Please specify: _____

Do you identify as (check all that apply):

- Straight Gay Lesbian Bisexual
- Other: _____

Please describe your current relationship status (check all that apply):

- Single Married In a civil union In a domestic partnership, living together
- Partnered, not living together Divorced Widowed
- In a committed relationship Other: _____

Which category best describes you? (check all that apply)

- American Indian or Alaska Native Asian Black or African American
- Hispanic, Latino or Spanish Origin Middle Eastern or North African
- Native Hawaiian or Other Pacific Islander White
- Some other race, ethnicity, or origin, please specify: _____
- I prefer not to answer.

How do you describe your religion, spiritual practice, or existential worldview?

Please specify: _____

I prefer not to answer

Education

Highest Grade Completed _____

If minor, name of school currently attending: _____

Employment

Occupation: _____

Employer: _____ How long at this employer? _____

Person Financially Responsible for Services: _____

	Name	Date of Birth
Address	Driver's License #	Social Security #
Insurance	Policy #/Group #	Authorization #

Main reason for seeking psychotherapy at this time:

Persons Currently Living With You:

Name	Age	Relationship to You

MEDICAL:

Primary Care Physician: _____ Telephone: (____) _____

Date of Last Physical Examination: _____ Reason: _____

Chronic Medical Conditions: _____

Operations, Head Injuries, Medical Illnesses (with dates): _____

Allergies and Drug Reactions: _____

CURRENT MEDICATIONS (including psychotropic medications):

Medication	Dosage	How Long Have You Been Taking?	Reason for Taking This Medication?	Name of Prescribing Physician

PREVIOUS MENTAL HEALTH CARE:**Previous Psychotropic Medications:**

Dates	Medication	Problem(s) Addressed	Result

Previous Mental Health Providers (therapists, psychiatrists, school counselors):

Dates	Provider's Name & Tel. #	Problem(s) Addressed	Result

Previous Psychiatric Hospitalizations:

Dates	Hospital/Location	Problem(s) Addressed	Result

FAMILY PSYCHIATRIC HISTORY:

Do you have any relatives that have had serious mental/emotional problems or alcohol/drug problems? If so, please list:

Relationship	Diagnosis	# of Hospitalizations

FAMILY-OF-ORIGIN HISTORY:

Relative	Name	Current Age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Stepparents					
Grandparents					
Uncles/Aunts					
Brothers					
Sisters					

EMERGENCY INFORMATION:

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Phone: (____) _____

Address: _____ City: _____ Zip: _____

Relationship to you: _____

CURRENT PROBLEMS OR SYMPTOMS

- Headaches
- Dizziness
- Stomach trouble
- Bowel trouble
- Back pain
- Tremors or tics
- Other physical problems

- Can't get to sleep
- Nightmares
- Trouble concentrating
- Memory problems
- Worry a lot
- Can't make decisions
- Tense/unable to relax
- Panicky feelings
- Unreasonable fears
- Fear of losing self-control

- Strange or unusual thoughts
- Hallucinations
- Repetitive thoughts/acts
- Feel others try to harm you

- Ready to explode
- Thoughts about harming someone
- Excessive use of alcohol/drugs

- Wake up at night or in the early morning & unable to return to sleep
- Loss of appetite
- Weight loss
- Unable to enjoy life
- Decreased sex drive
- Feel worthless
- Feel hopeless/helpless
- Thoughts of suicide
- No energy
- Sadness or depression
- Have withdrawn from others

- Weight gain

- Increased sex drive
- Increased energy
- Decreased need for sleep

- Family conflicts
- Work problems
- Can't make or keep friends
- Feel very shy or afraid to stand up for your rights

- Other: _____

