YANE BARRETO, LMHC, MHP, CMHS
Child and Family Therapist
Contact 206 229-6143
Address 8521 15th AVE NE
Seattle, WA. 98115

INTAKE FORM

Intake Date:____________
MM/DD/YY

CLIENT INFORMATION:

Name:_____________________________________ DOB:__________ Age:________
Address:_______________________________________ City: ______________ State:____ Zip______
Email address: ________________________________ Can I email you? Y / N
*Please note: Email correspondence is not considered to be a confidential form of communication.
Home phone: (____)_____-_________ Mobile phone: (____)_____-_________
*Is it acceptable to contact you at home? Y / N Can I leave a msg? Y / N
If "no" then how can I contact you? ____
Single ❑ Married ❑ Divorced ❑ Separated ❑ Co-habitating ❑ Gender:____
Emergency Contact: ________________________________ Home phone: (____)____-_______
Referred by (if any): ____

MEDICAL AND MENTAL HEALTH HISTORY

Are you currently under medical care? Y/N Describe:
____

Primary Care MD: ___________________________ Phone: (____)_____-_________
Are you currently taking prescribed medications? Y / N
If yes, then please explain/describe. ____
____
List any psychiatric/mental health medications you have taken. ____________________________
____
Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N
If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem which required attention. ____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
____
2. 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:
____

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in? ___________________________________

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

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No

□ Yes

If yes, for approximately how long? ____

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

□ No

□ Yes

If yes, when did you begin experiencing this? ___________________________________

7. Are you currently experiencing any chronic pain?

□ No

□ Yes

If yes, please describe: ____

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

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. What significant life changes or stressful events have you experienced recently:

Please circle any of the following struggles that pertain to you:

Anxiety Depression Fears/Phobias Eating Disorders

Sexual Problems Suicidal Thoughts Separation/Divorce Relationships

Finances Drug/Alcohol Use Career Choices Anger

Self-Control Unhappiness Insomnia Religious Matters

Work/Stress Health Problems Cutting/Self-Mutilation Thought Patterns

From the struggles that you marked above, which one concerns you the most? Is there any other struggle not listed, that you would like me to know about?

____

____

____

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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, grandmother, uncle, etc.).

	Please circle	Family Member
Alcohol/Substance Abuse	Y/ N	
Anxiety	Y/ N	
Depression	Y/ N	
Domestic Violence	Y/ N	
Eating Disorders	Y/ N	
Obesity	Y/ N	
Obsessive Compulsive Behavior	Y/ N	
Schizophrenia	Y/ N	
Suicide Attempts	Y/ N	
Other:	Y/ N	

ADDITIONAL INFORMATION:

1. 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?

____

____

2. What do you consider to be some of your strengths?

____

____

3. What would you like to accomplish in your therapy?

____

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