Peggy Burns, LMFT
Licensed Marriage and Family Therapist #41729
801 Portola Drive, Suite 108 ~ San Francisco, CA 94127

Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

Name: _____ Gender: _____ Date: _____

Date of Birth and Place of Birth: _____ Age: _____

Address: _____

Telephones: H: _____ Cell: _____ Work/Office: _____

For Routine Messages: Phone #_____ Email: _____

For Confidential/Private Messages: Phone #_____ Email: _____ Text: _____

Highest Grade/Degree: _____ Type of Degree: _____

Person & Phone No. to Contact in Emergency: _____

Referral Source: _____

Occupation (former, if retired): _____

Presenting Problem (be as specific as you can: when did it start, how does it affect you.):

_____

_____

_____

_____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

What are Your Goals for Therapy:

_____

_____

Current: Marital status: _____ Live with someone: _____ Name: _____Years: _____

Others Living With You: _____

_____

Past & Present Marriage(s) (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

_____

_____

_____

Present Spouse/Partner: Education: _____

Occupation: _____

Children/Step/Grand (names/ages & brief statement on your relationship with the person.)

1. _____
2. _____
3. _____

Parents/Stepparents (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father:_____

_____

_____

Mother: _____

_____

_____

Stepparents:_____

_____

_____

Siblings (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1. _____
2. _____
3. _____

Medical Doctor(s) (name/phone): _____

_____

_____

Past/Present Medical Care (major medical problems, surgeries, accidents, falls, illness, etc.):

_____

_____

_____

Specify Medication(s) you are presently taking and for what. Print clearly:

_____

_____

Past/Present Drug/Alcohol Use/Abuse (AA, NA, treatments):

_____

_____

Suicide Attempt(s) or Violent Behavior (describe: ages, reasons, circumstances, how, etc.)

_____

_____

Family Medical History (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):

_____

_____

Friendships, Community, Spirituality/Religious Preference:

_____

_____

Past/Present Psychotherapy (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

_____

2. _____

_____

3. *Use Other Side of Page to Add More Information About Psychotherapists, if Needed.*

Describe Your Childhood, in General (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

If Parents Divorced: Your age at the time: _____.

Describe how it affected you at the time

_____

_____

Estimate How Many Hours/Day You Spend Online (Facebook, YouTube, gaming, texting, browsing, etc.):
Facebook: _____ YouTube: _____ Gaming: _____ Texting: _____ Browsing: _____
Work/School: _____ Other: _____

Do You Feel Your Technology Use is Balanced and Healthy or Could it Use Improvement? Please explain:

Family History of Alcoholism, Mental Illness, or Violence (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):
_____

_____

Are You Involved in Any Current or Pending Civil or Criminal Litigation(s), Lawsuit(s) or Divorce or Custody Dispute(s)? (if you answer Yes, please explain):
_____

_____

What gives you the most joy or pleasure in your life?

_____

What are your main worries and fears?

_____

What are your most important hopes or dreams?

_____

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.

Reason for selecting a therapist with Christian Counseling Centers_____

_____