Karen E. Sumi, MFT

Intake and History

This information will help me understand your history and your concerns so that we can focus your therapy sessions in an efficient way. All material is confidential and will not be released without your written request.

Name: _____ Date of Birth: _____

Address: _____ Home phone: _____ ☐ Message OK

_____ Cell phone: _____ ☐ Message OK

Employer/School: _____ Work phone: _____ ☐ Message OK

E-mail Address: _____

Relationship Status: ☐ Married/Partnered ☐ Living together ☐ Single ☐ Divorced ☐ Widowed

How long in present status: _____ Prior partnerships (dates): _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Relevant medical conditions: _____

Medications (include reason and dosage): _____

_____

Who will participate in therapy?

Name	Age	Relationship	Phone number

Persons living in your home besides yourself:

Name	Age	Relationship

Please check any of the following you have experienced in the last year:

☐ Death of spouse/partner	☐ Marriage or new partnership	☐ Pregnancy/Birth
☐ Death of a family member	☐ Separation or Divorce	☐ Medical condition/issues
☐ Death of a close friend	☐ New family member	☐ Serious illness of family member
☐ Change in employment	☐ Family member left home	☐ Change in financial situation
☐ Job change for spouse/partner	☐ Moved residence	☐ Legal problems
☐ Started or finished school	☐ Sexual difficulties	☐ Other: _____

Please check any of the following you have experienced in the last two months:

☐ Tension or stress	☐ Frequently worried	☐ Depressed
☐ Unable to relax	☐ Ready to explode	☐ Thoughts of suicide or death
☐ Anxious or fearful	☐ Irritable	☐ Feeling worthless
☐ Excessive use of alcohol or drugs	☐ Unable to have a good time	☐ Trouble concentrating
☐ Sleep difficulties	☐ Lack of self-confidence	☐ Can't make decisions
☐ Nightmares	☐ Panicky feelings	☐ Impulsive behavior
☐ Conflict within family	☐ Conflict with friends	☐ Unable to work/study well

Do you drink alcohol or use other non-prescription drugs? If yes, please indicate type, amount and frequency:

_____

_____

Concerns

What is the major reason you are seeking help at this time? _____

_____

What have you tried so far to address your concerns? _____

_____

What do you think is causing or contributing to the problem? _____

_____

What would you like to get out of therapy? Please be specific regarding your goals: _____

_____

_____