TRANSFORMATIVE PSYCHOTHERAPY, L.L.C.
Jeannine K. Vegh, M.A., I.M.F.T.
Independent Marriage and Family Therapist #F1000006
2572 Oakstone Drive, Suite 4, Columbus, OH 43231
(614) 813-7677, transformpsych@jkvegh.com, http://jkvegh.com

INDIVIDUAL INTAKE FORM

Name: _____

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Email: _____ (Skype name) _____

1. Sex: □ Male □Female 2. Age: _____ Date of Birth: _____

3. Marital/Relationship Status: (underline)
Single (never married), Significant Other, Cohabiting (living together), First Marriage, Separated, Divorced, Widowed, Remarried (after divorce), Remarried (after spouse's death)

Spouse/Partner's Name: _____

4. Employment: (underline)
Full-time, Part-time, Homemaker, Unemployed, Student (FT or PT), Retired

Employer's Name and Address:

_____

5. Approximate current annual household income: _____

6. Children (include biological, adopted, foster, step, etc..):

Name	Sex	Age	Type (bio, step, etc..)	Custody
_____	___	____	_____	□ Yes □ No
_____	___	____	_____	□ Yes □ No
_____	___	____	_____	□ Yes □ No
_____	___	____	_____	□ Yes □ No

7. Education (highest level attended): _____

8. Race/Ethnicity: _____

9. Religion: _____

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10. Are you presently under a physician's care? Yes No

If yes, what for? _____

List any current medications and amounts: _____

_____

Name and address of physician: _____

_____

11. Please check any of the reasons listed below which resulted in your coming to see the therapist at this time:

□ Depression or Anxiety
□ Alcohol or other drug abuse
□ Marital problems
□ Communication difficulties
□ Relationship concerns
□ Abuse (previous or current)
□ Child adjustment/parent conflict
□ Divorce counseling
□ Sexual orientation questions
□ Harassment from others
□ Difficulty with loss or death
□ Thinking of harming self or others
□ Infidelity, Sexting or Internet Flirting/Sex
□ Family counseling
□ Improve sexual relations
□ Low Self-Confidence
□ Individual counseling
□ Pre-Marital counseling
□ Job, Creative or Academic stress
□ Other: ____

12. As you think about the primary reason that brings you here, how would you rate its frequency and your over-all level of concern at this point in time (note: a problem may occur rarely but be of serious concern, or occur frequently, but be of little concern)?

Concern
□ No concern
□ Little concern
□ Moderate concern
□ Serious concern
□ Very serious concern

Frequency
□ No occurrence
□ Occurs rarely
□ Occurs sometimes
□ Occurs frequently
□ Occurs nearly always

13. Have you ever received prior counseling related to these or other problems? Yes No

If yes, was it: Outpatient Inpatient

When: _____ Where: _____ Length of Treatment: _____

By whom: _____

Problems treated: _____
Outcome: □ Very Successful □ Somewhat Successful □ Stayed the Same
□ Somewhat worse □ Much Worse

Other treatment: Outpatient Inpatient

When: _____ Where: _____ Length of Treatment: _____

By whom: _____

Problems treated: _____
Outcome: □ Very Successful □ Somewhat Successful □ Stayed the Same
□ Somewhat worse □ Much Worse

14. How did you learn about Ms. Vegh? □ Website □ Advertisement □ Insurance EAP
□ Aquaintance/Friend □ Family Member

Whom were you referred by: _____

15. Person to contact in case of an emergency:

Name: _____

Address: _____

Phone: (Home) _____ (Work) _____(Cell) _____

Relation of this person to you? _____

_____ _____
Client Signature Date