Howard P. Goodman, LMFT
Psychotherapist
Marriage Family Therapist, MFC # 46896

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: ____
(Last) (First) (Middle Initial) Social Security #

Name of parent/guardian (if under 18 years):
____
(Last) (First) (Middle Initial) Social Security #

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Address: ____
(Street and Number)
____
(City) (State) (Zip)

Home Phone: (   ) _______________________ May we leave a message? □Yes □No

Cell/Other Phone: (   ) __________________ May we leave a message? □Yes □No

E-mail: ____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed
Please list any children/age: ____

Insurance information
Patient name __________________________________ Date of Birth _____ / _____ / ____

Name of Policy Holder __________________________ Date of Birth _____ / _____ / ______

Name of Insurance Plan ____________________ Plan ID#_______________________

5525 Oakdale Avenue, Suite #410, Woodland Hills, CA 91364
Tel: 818-754-8644 / howard@howardpgoodman.com

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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:
____

How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Describe: ____

Do you get regular exercise? If so, what kind and how often? ____________________
____

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

Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes If yes, for approximately how long? _______________________

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes If yes, when did you begin experiencing this? __________________________

Are you currently experiencing any chronic pain?
□ No □ Yes If yes, please describe? ____
____

Are you currently taking any prescription medication?
□ Yes □ No (If yes, please list) ____
____

Have you ever been prescribed psychiatric medication?
□ Yes □ No (If yes, please list) ____
____

How often do you drink alcohol?
□ Never, □ Infrequently, □ 1-2 drink per day, □ 3 + drinks per day

How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
If Yes, which substances____

Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? ___________________

On a scale of 1-10, how would you rate your relationship? ___________

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

On a scale of 1-10, how would you rate your current level of happiness? __________

FAMILY MENTAL HEALTH HISTORY:

	Please Circle	Relationship
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

What do you consider to be some of your strengths?
____
____

What would you like to accomplish in therapy?
____
____