1740 La Costa Meadows Drive
Suite 141
San Marcos, CA 92078

LITSA BRADFORD, MA, LMFT
760-218-5905
litsa@litsabradford.com

71777 San Jacinto Drive
Suite 204
Rancho Mirage, CA 92270

Couples Counseling Intake Information

Each partner must complete their own copy of this form

General Information

Your Name____ Today's Date _____________

Full Address ____

Phone _________________________ Email ____

Please mark all ways I may contact you: ___Phone ___Text ___Email

Age _________ Date of Birth _____________ Referred By _________________________________

Occupation ____ Educational Level _______________

Relationship Status: __married or live together __live separately __live with parents

Names/Ages of Your Children____
(For blended families, do not include children brought to the relationship by your partner)

Military
Are you a veteran or current member of the U.S. Military/Reserves __yes __no

Please describe ____

Financial Information

If you want to have services billed through your insurance, please provide the information here:

____
Insurance Carrier

____
Primary Insured Person Name & Relationship

____
Your Member ID & Group Number

____
Primary Insured's Date of Birth

____
Authorization Number (if known)

____
Date of Authorization and # of Sessions

Annual Household Income ______________________ # People in Household __________________

Sessions are a full 60 minutes at $150.00 paid at time of session, unless other arrangements have been made and/or unless other requirements/restrictions are imposed by your insurance carrier. Insurance carriers do not pay for cancellations and no-shows. You are responsible for the full fee set by your insurance carrier for non-emergency cancellations made less than 24 hours in advance. No-shows will be billed to you at my full rate. Please initial that you understand and agree to these payment terms: ________________

Areas of Concern

What concerns led you to seek treatment? ____

____

Do you have any specific goals with regard to your treatment? ___________________________

____

Do you have any particular concerns/fears with regard to your treatment? __________________

____

Psychological History

Have you ever received counseling/mental health treatment before? __yes __no

If yes, briefly state when and why ____

Have you ever been hospitalized for mental, emotional or addiction issues? ________________

Please list any medications for a mental or emotional issue you currently take or have taken in the past:

____

Patient may be asked to sign an authorization for release of confidential health information so that any former or current health care provider or therapist may be contacted in order to provide relevant information to support or inform your current treatment here.

Have you ever attempted suicide? How old were you?______________________________

Are you currently having any suicidal thoughts? _________________________________

Were you ever subjected to verbal, emotional, physical or sexual abuse? ________________

If yes, by whom and when? ____

____

Medical History

Have you ever been diagnosed with a serious illness? Please describe:

____

Are you currently experiencing any medical/physical/pain symptoms that you attribute to a mental, emotional or stress-related condition? Please describe:

____

Current Status

In the following two categories, please circle the best description of **how you have felt (on average) over the past two weeks:**

Very Sad/Depressed *A little down* *Just OK* *Pretty OK* *Happy/Satisfied* *Elated/Excited*

AND:

Severe/Constant Anxiety *Worried* *Just OK* *Pretty Calm* *Relaxed/Satisfied* *Enlightened*

Please feel free to include any other information that you believe is relevant to your mental health treatment:

____

____

Thank you!