Psychotherapy Office of Jessica Cliff, M.S., MFT
License # MFC 45576
2 Crow Canyon Court, Suite 110, San Ramon, CA 94583
925-328-0186
jessicacliffmft@yahoo.com

PSYCHOTHERAPY INTAKE FORM

Name: Date:

Street: City: State: Zip:

Home Phone: Cell Phone:

Employer: Work Phone:

Work Address: Occupation:

E-mail: Referred by:

Sex: M F Ethnicity: Date of Birth: Age:

Marital Status: (Circle all that apply) Married Single Engaged Living Together Separated Divorced Widowed

Name of Spouse: Spouses Employer:

Names of Children:	Age:	Gender:	Living w/ you?	Comments:
_____	_____	M F	Yes No	_____
_____	_____	M F	Yes No	_____
_____	_____	M F	Yes No	_____
_____	_____	M F	Yes No	_____

Briefly state your reason for seeking counseling at this time.

Have you ever been seen by a mental health professional before? Yes No
If yes, please indicate who, when and why.

Would you consent for myself, Jessica Cliff, MFT to contact him/her? Yes No

Do you regularly practice relaxation techniques (i.e. meditation, yoga, other?)
If yes, what and how often?_____

How often do you get 20 minutes or more of exercise?_____

How many caffienated drinks (coffee, soda, tea hot chocolate) do you drink per day?_____

How much do you smoke?_____

How much do you usually drink?_____

Do you use "recreational" drugs? Yes No If yes, what and how often?_____
_____

Please list any troublesome or significant medical conditions you may have.

Please list your current medications (Prescription & Non):

1.
2.
3.
4.

Who should be contacted in case of an emergency?

Name: Phone: Cell: