

THUY CAO
~ Pronounced Twee Cow ~
LICENSED MARRIAGE AND FAMILY THERAPIST

Office: 424-835-0880

tcaomft@yahoo.com

CLIENT INTAKE FORM

Please complete the information below. All information is CONFIDENTIAL.

Today's Date: _____ Referred By: _____

Patient Information

Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____

State: _____ Zip: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

Circle the telephone #(s) I may leave messages at? Home / Work / Cell Email Address: _____

Employer: _____ Occupation: _____

Job Satisfaction: High / Medium / Low Years employed with this company or Self Employment: _____

Education / Degree(s) Obtained: _____

Name of person to contact in an emergency: _____

Relationship: _____ Phone #: _____

Briefly describe your reason for seeking my services at this time.

What would you most like to address in our work together?

Have you been in therapy before? If so, please describe the reason for therapy at that time and whether you felt positively about your experience.

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Relationship Information

Are you currently in a relationship? Yes__ No__ If yes, number of months or years together: _____

Married / Domestic Partnership? Yes__ No__ If yes, number of months or years together: _____

Separated/Divorced? Yes__ No__ Not Applicable __ If yes, for how long? _____

Name of Spouse/Partner: _____

Name(s) & age(s) of Child(ren): _____

Are you presently involved in any custody disputes? Yes__ No__

Are you presently involved in any legal disputes /lawsuits/divorce/custody/workers comp? Yes__ No__

Health History

Do you have any major illnesses or disabilities? _____

Doctor's Name: _____

Have you seen a psychiatrist in the past five years? Yes__ No__

Doctor's Name/Phone: _____

What medications do you currently take? Please include dosage. _____

Do you smoke? Yes__ No__

Drink alcohol? Never __ Monthly __ Weekly __ More than 3 days a week __

Daily Drugs? Never __ Monthly __ Weekly __ More than 3 days a week __

Exercise? Yes__ No__ If yes, 1 to 2 times/wk __ 3 to 4 times/wk __ 5 to 7 times/wk __

Have you ever been hospitalized for treatment of a psychological condition or substance abuse problem?
Yes__ No__ If yes, briefly describe the outcome and treatment

Family History

Are you adopted? Yes__ No__ If yes, please indicate your age, placements and any contact you have had with your biological parent(s)?

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Did you grow up with your biological parents? Yes__ No__ If no, please describe your living situation:

Were there any major separations from your parents or traumatic events that you identify, such as divorce, illness, hospitalization of parent or sibling, marital separations, moves, etc.

Give a brief description of your relationships with the following persons and note any significant health and/or psychological history such as alcoholism, depression, anxiety, suicide attempt, etc.

Mother _____

Father _____

Stepfather _____

Stepmother _____

Sibling (s) _____

Spouse/Partner _____

Ex Spouse/Partner _____

Child(ren) _____

Additionally, I would like you to know.....
