

**Deborah Lakeman M.A.**  
**Licensed Marriage and Family Therapist**  
**LMFT #48789**  
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**Burbank, Ca. 91505**  
**818 980-8870**

# I N T A K E   F O R M

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

Please fill out this form and bring it to your first session.

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last)                      (First)                      (Middle Initial)

Name of parent/guardian (if under 18 years):

\_\_\_\_\_  
(Last)                      (First)                      (Middle Initial)

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:

Never Married  Domestic Partnership  Married  Separated

Divorced  Widowed

Please list any children/age: \_\_\_\_\_

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.

Emergency Contact:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Referred by (if any): \_\_\_\_\_

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No

Yes, previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication?

Yes

No

Please list: \_\_\_\_\_

\_\_\_\_\_

Have you ever been prescribed psychiatric medication?

Yes

No

Please list and provide dates: \_\_\_\_\_

\_\_\_\_\_

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

1. 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:

\_\_\_\_\_

2. How would you rate your current sleeping habits? (please circle)

Poor      Unsatisfactory      Satisfactory      Good      Very good

Please list any specific sleep problems you are currently experiencing:

\_\_\_\_\_

3. How many times per week do you generally exercise? \_\_\_\_\_

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What types of exercise to you participate in \_\_\_\_\_

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

\_\_\_\_\_

5. Are you currently experiencing overwhelming sadness, grief or depression?

- No  
 Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing suicidal thoughts?

- No  
 Yes

If yes, for approximately how long? \_\_\_\_\_

If yes do you currently have a plan? \_\_\_\_\_

7. Are you currently experiencing anxiety, panic attacks or have any phobias?

- No  
 Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

8. Are you currently experiencing any chronic pain?

- No  
 Yes

If yes, please describe \_\_\_\_\_

9. Do you drink alcohol more than once a week?  No  Yes

10. How often do you engage recreational drug use?  Daily  Weekly  Monthly  
 Infrequently  Never

11. 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? \_\_\_\_\_

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

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**FAMILY MENTAL HEALTH HISTORY:**

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space p grandmother, uncle, etc.).

	Please Circle	List Family Member
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:**

1. Are you currently employed?  No  Yes

If yes, what is your current employment situation:

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Do you enjoy your work? Is there anything stressful about your current work?

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2. Do you consider yourself to be spiritual or religious?  No  Yes

If yes, describe your faith or belief:

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3. What do you consider to be some of your strengths

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4. What do you consider to be some of your weakness?

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5. What would you like to accomplish out of your time in therapy?

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_