jon b. pease, ma, lmft
12304 Santa Monica Blvd, 327
Los Angeles, CA 90025

310 692 4114
jp@jonpease.com

MFC48823

Intake Form

Welcome to my office. Please take a few minutes to fill out the questionnaire and bring to your session.
All information is held in confidence and will not be shared unless your safety is at risk.

Your Name				Today's Date	
DOB	Age	☐ Male	☐ Female	Email	
Street Address				Who can I thank for referring you?	
City				State: CA	Zip
Home Phone				Ok to leave message? ☐ Yes ☐ No	
Work Phone				Ok to leave message? ☐ Yes ☐ No	
Mobile Phone				Ok to leave message? ☐ Yes ☐ No	
Marital Status: ☐ Single/Engaged ☐ Married ☐ Divorced ☐ Widowed ☐ Other					
Spouse/Partners Name				DOB	
Date Relationship Began				Rate Quality of Relationship ☐ Excellent ☐ V. Good ☐ Good ☐ Fair ☐ Poor	
Best Number to Contact Partner/Spouse					
Child Name				Child's Age	Legal Custody
Child Name				Child's Age	Legal Custody
Child Name				Child's Age	Legal Custody
Child Name				Child's Age	Legal Custody
Emergency Contact Name				Emergency Contact Number	
Emergency Contact Relationship to you				Emergency Contact Email	

Prior Therapists Name	Last seen	Reason for ending
Address		

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Primary Care Physician	Last Seen	
Phone Number	Fax Number	
Address	City, State Zip	
Employer	Employer Address	
Years at Occupation	City, State Zip	
Primary Insurance Name	Policy Number	
Subscribers Name	Subscriber ID	
Phone Number	Renewal Date	
Primary Care Physician	Phone Number	Last Seen
Address	City, State Zip	
Psychiatrist's Name	Phone Number	Last Seen
Address	City, State Zip	

Why are you seeking therapy now?
Was there an event that caused these problems?
How often do you use alcohol or other drugs? ☐ More than Once a Day ☐ Daily ☐ Every Few Days ☐ Weekly ☐ Rarely ☐ Never
How much do you consume in that period? ☐ 0-1 ☐ 2-5 ☐ 5+

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Pre-Treatment Survey

	N/A	Mild	Moderate	Severe	Constant
Concerns about body or physical health					
Thoughts or behaviors you do over and over again					
Unusually high energy/Long periods of high energy					
Feeling sad, blue or depressed					
Anxiety, nerves or tension					
Anger, hostility, or irritability					
Fears of things are places					
Beliefs that others want to hurt you					
Drinking/Smoking more than you think you should					
Trouble saying 'no' to others					
Unreal, strange or uncommon thoughts					
Voices					
Thoughts of hurting yourself					
Thoughts of hurting others					
Medical worries					
Lack of social support					

How are you doing?

	N/A	No Problems	Mild Problems	Moderate Problems	Severe Problems	Constant
On your job						
Primary Relationship (marriage, partner)						
Family (dad, mom, brother, sister)						
Friends/Non-family members						
Sleeping						
Eating						
Exercise						
Pain						
Flashbacks						
Bored						
Inability to focus						
Avoiding situations						
Feelings of dread or doom						
Frequent arguments with partner						
Other: Specify _____						

What are your spiritual/religious beliefs?
What are your strengths?
What are your goals for therapy?

Thank You!