310-612-1113
nmacaluso1@me.com

www.nadinemacaluso.com
License #81854

DR. NADINE MACALUSO
licensed marriage & family therapist

Intake Form

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.

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.*

Referred by (if any): _____

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐Yes ☐No , 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? _____ What types of exercise to you participate in?

_____

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

_____

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

☐Yes ☐No

If yes, for approximately how long? _____

_____

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

☐Yes ☐No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

☐Yes ☐No

If yes, please describe: _____

8. Do you drink alcohol more than once a week?

☐Yes ☐No

9. How often do you engage recreational drug use?

☐Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never

10. Are you currently in a romantic relationship?

☐Yes ☐No

If yes, for how long? _____ On a scale of 1-10, how would you rate your relationship? _____

11. 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 provided (father, grandmother, uncle, etc.). Please Circle

	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	_____

RISK ASSESSMENT

1. Any risk factors present? ☐Yes ☐No If yes, specify current risk factors
Potential for violence: yes/no
Hostile/ Abusive behavior: yes/no
Major Depression: yes/no
Suicidal Ideation/Intent/Plan: yes/no

PAST RISK FACTORS
Suicide Attempts: yes/no
Violent Behavior: yes/no
Inpatient Hospitalization: yes/no
Hostile/Abusive behavior: yes/no
Major Depression: yes/no
Suicidal Ideation/Intent/Plan: yes/no

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ADDITIONAL INFORMATION

1. Are you currently employed? ☐Yes ☐No If yes, what is your current employment situation? _____

_____

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

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐Yes ☐No If yes, describe your faith or belief: _____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____