Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Sex: ◯ Male ◯ Female

Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail? ◯ *YES* ◯ *NO*

Email: _____

Would you like to receive email communication? ◯ *YES* ◯ *NO*

Is it ok to send something in the mail? ◯ *YES* ◯ *NO*

How were you introduced to Phoenix Therapeutic Solutions (personal referral, insurance, online search, social media)?

_____

**** Please complete below for additional client***
(if client is a minor please list parent's/legal guardian's information below)

Name: _____

DOB: _____ Age: _____ Sex: ◯ Male ◯ Female

Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phoenix Therapeutic Solutions, P. A.
Dr. Andrea Cuva, LMFT, MCAP
954-870-0475
3038 N. Federal Highway, Suite F-2, Fort Lauderdale, FL. 33306,
101 Plaza Real S., Suite 226, Boca Raton, FL. 33432

New Client Intake Form

Phone Number(s): _____

Is it ok to leave a voicemail? ◯ *YES* ◯ *NO*

What are the 3 biggest concerns you have right now? How long have each been going on?

1. _____
2. _____
3. _____

Have you had therapy in the past? If so, with whom and when? What reason(s) did you attend therapy? What was helpful? Unhelpful?

_____
_____
_____

Change is Coming…

What are you hoping to gain from therapy? What expectations do you have of me as your therapist?

_____
_____

Looking into the future, how will you know that our work and time together has been worth it? What differences will you notice?

_____
_____

Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future?

_____
_____

Have you ever received psychiatric services before? ◯ YES ◯ NO

If yes, how long ago, with whom, for what, medications prescribed and results:

_____
_____

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Are you presently under a physician's/psychiatrist's care? If so, for what reason?

Is there anyone in your life that is currently dealing with a medical issue that you are concerned about? If so, whom, for what?

In the past year, have there been any changes in your life? (i.e.: moves, appetite, sleep, health, family, overall functioning)?

Important Questions We Must Ask

Have you ever had suicidal ideations? ◯ YES ◯ NO
If yes, please explain:

Have you ever planned to hurt yourself? ◯ YES ◯ NO
If yes, please explain:

Have you ever attempted to hurt yourself? ◯ YES ◯ NO
If yes, please explain:

Have you ever felt like you wanted to seriously hurt or harm someone else? ◯ YES ◯ NO
If yes, please explain:

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Do you have weapons in your home or access to weapons? ◯ YES ◯ NO
If yes, who has access to them and what are the safety protocols around them?

Is there any history past or present of abuse or violence? ◯ YES ◯ NO
If so, please explain:

Are you currently using any illegal drugs, or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related? ◯ YES ◯ NO

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

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