Marty Devins Horvath, LMSW
Licensed Master Social Worker | KS License #7387
mdcserenity@gmail.com | PH: 913-515-7769

INTAKE FORM

Date:____________________________

Last Name:_____________________________ First Name:_______________________________

Birthdate: _____________________________ Age:__________________________________

Address:_____________________________ City/State/Zip______________________________

How long at this address:____

Please provide contact phone number(s) and indicate your preferred number.

Home Phone:_________________ Leave a message?___yes ___no preferred? ___yes ____no

Cell Phone:__________________ Leave a message?___yes ___no preferred?___yes ____ no

Work Phone:_________________ Leave a message?___yes ___no preferred?___yes _____no

Email:____

Text messaging?____yes ___no preferred?___yes _____no

Referred by: ____

Do I have your permission to thank the person who referred you? _____yes ____no

Name:____Phone:__________________________

☐Married ☐Single ☐Separated ☐Divorced ☐Widowed ☐Committed Relationship ☐Living Together

Spouse's Name:___________________________ Birthdate:________________Age:__________

Date of current marriage:____

Previous marriage(s) for husband? How many?_________ Duration of each:______________

Previous marriage(s) for wife? How many?_________ Duration of each:______________

Names and ages of children:____

____

Names and ages of present household members: ___________________________________

____

Are there any serious medical problems or physical disabilities in your immediate family (parents, siblings, children)?____

____

Last Grade completed/degree(s)? You: ________________ Spouse:____________________

Your employer:_____________________________________ Phone:______________________

Occupation:______________________________ Length of time on job:___________________

Spouse's employer:_________________________________ Phone:______________________

Occupation: ______________________________ Length of time on job:___________________

Nearest relative not living with you: ___________________Phone:___________________

Marty Devins Horvath, LMSW

INTAKE FORM
(continued)

Whom may we contact in case of an emergency who does not reside with you?_______
____ Phone:____________________

Briefly, how would you describe the situation or problem that brings you here:________
____
____
____

Are you taking any medications? If yes, what, how much, and with what results:_______
____
____

What actions, if any, have you taken toward finding a solution?_____________________
____

Role of religion and/or spirituality in your life:
In childhood:____
As an adult:____

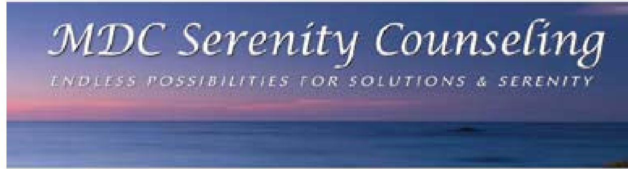
Present interests, hobbies and activities:_______________________________________
____

How do you spend most of your free time?______________________________________
____

Have you or any other family member ever received prior counseling or treatment?
☐ Yes ☐ No
If yes, whom and when?____
What do you expect from therapy and how long do you expect therapy to last?________
____
____

What is there about your present behavior that you would like to change?_____________
____
____

In a few words, what do you think therapy is all about?_____________________________
____
____



Marty Devins Horvath, LMSW

INTAKE FORM
(continued)

Presenting problems: (check all that apply in attending couples counseling please put your initials next to the problems that apply)

___very happy
___irritable
___temper oubursts
___withdrawn
___daydreaming
___fearful
___worry
___overactive
___slow
___short attention span
___distractible
___lacks initiative
___undependable
___social problems
___crying spells
___hair pulling

___impulsive
___stubborn
___panic attacks
___lying
___mean to others
___destructive
___trouble with the law
___health problems
___selfmutilating
___stressed ou
___relationship problems
___shy
___strange behavior
___strange thoughts
___physical abuse
___sexual abuse

___parenting problems
___stealing
___repetitive/ritualistic behaviors
___grief
___employment problems
___financial stress
___legal problems
___violence
___eating problems
___sleeping problems
___sexual problems
___drug use
___alcohol use
___suicidal thoughts
___homicidal thoughts
___

Explain:

____
____
____
____
____

What are your goals for treatment?

____
____
____
____
____

Is there anything else you feel is important for your therapist to know?

____
____
____
____
____
____

Marty Devins Horvath, LMSW
Licensed Master Social Worker | KS License #7387
mdcserenity@gmail.com | PH: 913-0515-7769

STATE OF KANSAS PHYSICIAN CONSULT

I understand that when I describe symptoms that may be consistent with a mental disorder, these symptoms can have medical orbiological origins and that my therapist must consult with my physician, unless I waive this requirement.

☐ No, I do not want my therapist to contact my physician and I waive this requirement. (Please sign below.)

_______________________________________ _______________________
Client Signature Date

☐ Yes, I request that my therapist consult with my physician regarding my mental health. (Please sign below.)

_______________________________________ _______________________
Client Signature Date

Physician's Name: ____
Address: ____
Phone Number: ____

_______________________________________ _______________________
Client Signature Date

_______________________________________ _______________________
Witness Signature Date