Maya Sprague
Holistic Psychotherapist

Intake Form

Date _____

Name
Last: _____ First: _____

Address_____

City _____ State _____ Zip_____

Email Address _____

Home Phone _____ Work Phone _____

Sex (male, female, transgender, intersex, non-binary, two-spirit, etc.) _____

DOB _____

Social Security # _____

Ethnicity _____

Employer _____ Position_____
Title/Rank/Student, etc.

Which phone number may I use to:

call you? _____

leave a voicemail? _____

leave a text? _____

If "no" then how may I contact you? _____

Insurance Carrier_____

Group/ID # _____ OR Private Pay *(Circle if not using insurance)*

Insurance Carrier Phone # _____

1622 3rd Street
Suite 9
Marysville, WA 98270

425.418.2949
maya@mayasprague.com
www.mayasprague.com

Relationship Status *(Circle one)*: Single Married Divorced Widowed Remarried

Spouse: Male/Female Name: _____Age_____

Child: Male/Female Name: _____Age_____

Child: Male/Female Name: _____Age_____

Child: Male/Female Name: _____Age_____

Child: Male/Female Name: _____Age_____

Child: Male/Female Name: _____Age_____

What is your preferred Spiritual Belief/Practice? _____

Are you currently under medical care? Y / N

If yes, then please explain/describe. _____

_____

_____

Name of Personal Physician & Phone Number:

_____

Are you currently taking prescribed medications? Y / N

If yes, then please explain/describe <u>all</u> medications you are currently taking.

	Medication/Dose	Purpose
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

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Have you been under the care of a psychiatrist, psychologist, or counselor? *(Circle one)* YES NO

If yes, please give the name, date, and location of the therapy and briefly explain the nature of the issues addressed.

_____ _____ _____

Date(s) *Name of Professional* *City/State*

_____

Nature of problem

_____ _____ _____

Date(s) *Name of Professional* *City/State*

_____

Nature of problem

Have you experienced suicidal thoughts or attempts in the past? YES NO

Are you ***currently*** experiencing suicidal thoughts, intent, and/or plans? YES NO

Have you experienced hallucinations in the past (visual, audible, tactile)? YES NO

Are you ***currently*** experiencing hallucinations (visual, audible, tactile)? YES NO

Have you had any prior hospitalizations for mental health issues? *(circle one)* YES NO

If so, please list the dates and reasons for your admission.

_____ _____ _____

Date *Hospital* *Reason for Admission*

_____ _____ _____

Date *Hospital* *Reason for Admission*

Please circle any of the following struggles that pertain to you:

Anxiety	*Depression*	*Fears/Phobias*	*Eating Disorders*
Sexual Problems	*Suicidal Thoughts*	*Separation/Divorce*	*Relationships*
Finances	*Drug/Alcohol Use*	*Career Choices*	*Anger*
Self-Control	*Unhappiness*	*Insomnia*	*Religious Matters*
Work/Stress	*Health Problems*	*Cutting/Self-Mutilation*	*Thought Patterns*

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