Cardiff Counseling Center

Individual, Couples & Family Therapy
Bonnie J. Rumble, MFT • License #MFC 31229
Locations in Cardiff & San Diego
760-815-2261 – bonnie@cardiffcounselingcenter.com

## Intake Information Form

Today's date_____

Name(s): _____ SSN: _____-___ -_____Birth Date_____

Name(s): _____ SSN: _____-___ -_____Birth Date_____

Address_____ Email_____

City _____ State _____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone: _____

Occupation _____Employer _____ How Long _____

Relational Status_____ Name of Spouse/Partner_____

How Long Have Both of You Been Together? _____No. of Dependents_____

Name of Closest Friend/Relative_____ Phone_____

Address _____City_____ State_____ Zip_____

*THERE ARE TIMES WHEN PRIOR MEDICAL AND PSYCHOLOGICAL RECORDS WILL BE REQUESTED. PLEASE MAKE SURE THAT ALL INFORMATION GIVEN BELOW IS CORRECT.*

Do You Smoke? Y N How Much? _____Do You Drink? Y N How Much? _____

Do You Take Drugs? Y N If yes, what kind? _____ How often? _____

Last Medical Examination_____ Reason_____

Are You Now Under a Doctor's Care? _____ If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Please list Medication(s) & their Dosages you are currently taking: _____
_____

Reason for Medication(s): _____

Have you ever been hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe: _____

Any Previous Therapy/Counseling? Y N If Yes, Name and Phone Number(s) of Therapists: _____

_____

When and Number of Sessions: _____

Type of Therapy/Counseling: _____

How referred for therapy? _____

What do you wish to achieve with Therapy? _____

_____

_____

**CHECK ANY OF THE FOLLOWING THAT MAY APPLY TO YOU (AND PARTNER IF APPLICABLE):**

☐☐ Headaches
☐☐ Dizziness
☐☐ Fainting Spells
☐☐ No Appetite
☐☐ Over-Eating
☐☐ Stomach Trouble
☐☐ Bowel Disturbances
☐☐ Always Tired
☐☐ Always Sleepy
☐☐ Unable To Relax
☐☐ Insomnia
☐☐ Recurrent Dreams
☐☐ Nightmares
☐☐ Hallucinations

☐☐ Inferiority Feelings
☐☐ Feel Tense
☐☐ Feel Panicky
☐☐ Fears and Phobias
☐☐ Obsessions
☐☐ Depressed
☐☐ Suicidal Ideas
☐☐ Take Tranquilizers
☐☐ Alcoholism
☐☐ Dangerous Drugs
☐☐ Allergy
☐☐ Asthma
☐☐ Sexuality Issues
☐☐ Sexual Problems

☐☐ Shy With People
☐☐ Can't Make Friends
☐☐ Afraid Of People
☐☐ Home Conditions Bad
☐☐ Unable To Have a Good Time
☐☐ Always Worried About Something
☐☐ Don't Like Weekends/Vacations
☐☐ Can't Make Decisions
☐☐ Over-Ambitious
☐☐ Financial Problems
☐☐ Gambling
☐☐ Job Problems
☐☐ Can't Keep a Job
☐☐ Other

**CANCELLATION POLICY**

Client is responsible for payment of the agreed upon fee for any missed session(s). Client is also responsible for payment of the agreed upon fee for any session(s) for which Client failed to give Therapist at least **24 hours' notice of cancellation**. Cancellation notice should be left on Therapist's voicemail at 760-815-2261.

*Upon my signature below, I hereby attest that all the information furnished is true and correct.*

Client's Signature: _____ Date:_____/_____/_____

Client's Signature: _____ Date:_____/_____/_____

Therapist Signature: _____ Date:_____/_____/_____

Parental Consent Signature: _____ Date:_____/_____/_____
*Parental Consent if client is a minor

Informed Contract signed (Client's Initials) _____ Informed Contract signed (Therapist's Initials) _____

*Rev. 04/14*