Marriage and Family Therapy Intake Form

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This is a CONFIDENTIAL DOCUMENT.
Please leave any question blank that you would rather not answer.
Note that information you provide here is held to the same standards of confidentiality as our therapy sessions.

Your Name: Today's date:

_____ _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Your birth date: _____ /_____ /_____ Current age: _____ Gender: ____ Male ____Female

Contact Information

Home Phone: _____ May I leave a message? ____Yes ____No

Cell/Other Phone: _____ May I leave a message? ____Yes ____No

E-mail*: _____ May I email you? ____Yes____No

*Please note: Email correspondence is not considered a confidential form of communication.

Home Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Emergency Contact Information:

_____ _____ _____
(Name) (Relationship to you) (Phone number)

_____
(Alternate phone number)

Current Relationship Status:

____Never Married
____Domestic Partnership (# of yrs:_____)
____Divorced (# of yrs:_____)
____Married (# of yrs:_____)
____Separated (# of months:_____)
____Widowed (# of yrs:_____)

FAMILY

List any children and stepchildren and their current age(s):

Youngest child's name	current age	living at home?	If no, where?
Child's name	current age	living at home?	If no, where?
Child's name	current age	living at home?	If no, where?
Child's name	current age	living at home?	If no, where?
Child's name	current age	living at home?	If no, where?
Child's name	current age	living at home?	If no, where?

List other individuals living with you:

Name	current age	relationship to you
Name	current age	relationship to you
Name	current age	relationship to you
Name	current age	relationship to you

Do you have grandchildren? ___No ___Yes If yes: how many? ____ How many live nearby? _____

List any pets or animals that you have:

Name	Type	approximate age
Name	Type	approximate age
Name	Type	approximate age

_____

Name Type approximate age

EMPLOYMENT

If currently employed, please complete the following:
Name and address of employer:

_____

_____

On a scale from 1 to 10, where 10 is extremely happy, rate your job satisfaction: _____

List stressors at work:

HEALTH

Primary care physician: _____ Phone Number:_____

Physician's Address:

_____

(Street and Number) (City) (State) (Zip)

May I contact your physician to inform him or her of your beginning treatment with me?

__Yes, __No permission is granted to inform the referring physician that I am being treated.

Are you currently taking psychiatric medication?

___No ___Yes. If yes, please list and include their purpose:

_____

_____

Are you currently taking any medications or supplements for other reasons?

___No ___Yes. If yes, please list medications and their purpose:

1._____
2._____
3._____
4._____
5._____
6._____
7._____

8._____
9._____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

___No ___Yes If yes, where and for what reason:

_____

_____

Have you ever seen a therapist before?

___No ___Yes If yes, why did you stop?

_____

_____

Please list any other professionals (name and type) whom you are currently seeing (i.e., doctors, chiropractor, naturopath, acupuncturist, etc.) **and why**.

_____

_____

_____

Do you regularly drink alcohol? ___ No ___ Yes
If yes, in a typical month, approximately how often do you have 4 or more drinks in a 24 hour period?
_____

Do you engage in recreational drug use? ___ No ___ Yes
If yes, in a typical month, how often and what types? _____

On a scale from 1 to 10, where 10 is excellent or healthy, how would you rate yourself regarding:

a. your eating habits a. _____

b. your ability to sleep through the night b. _____

c. getting regular exercise c. _____

d. your physical health d. _____

e. your relationships with family members e. _____

f. your ability to deal with stress f. _____

g. your self esteem and confidence g. _____

h. your ability to seek emotional support from personal friends h. _____

Please list the number of times per week you generally exercise and the types of exercise you do (e.g., walk, lift weights, yoga, bowl, etc.).

Type of exercise: _____ Times per week: _____

Type of exercise: _____ Times per week: _____

Type of exercise: _____ Times per week: _____

STRESS

We all have stress in our lives. When you are stressed,

a. Where do you experience it in your body? What internal physical reaction(s) do you have or notice?

b. What is your typical emotional reaction?

c. How would others describe your behavior under stress?

List the strategies or things you presently use to manage your stress:

a. Each day:

b. On a weekly basis:

c. About once each month:

LIFE CHANGES

List any significant life changes, losses, or stressful events you have experienced within

a. the last week:

b. the last few months:

c. the last 6 to 12 months:

List other significant events that occurred more than one year ago and dating back to your childhood that still impact you today. In addition, describe any special circumstances with regard to your birth history:

RESOURCES

Overall, <u>what human resources</u> do you turn to when you need emotional support during stressful times? Circle all that apply.

My spouse or partner	My friends	Colleagues at work
My family members:	My religion/church:	Support groups: (list)
--parents	-- people who attend	
--siblings	--my religious leader	
--others: (which ones? List:)		Other: (list)

Overall, <u>what activities</u> do you turn to when you need relief during stressful times? Circle all that apply.

Exercise religious based meditation inspirational readings alcohol recreational drugs

Others: (describe) _____

RELIGION/SPIRITUALITY

Do you consider yourself to be spiritual or religious? ___No ___ Yes

If yes, please describe your faith or belief(s):

If yes, how often to you practice your religion either at home or outside the home? _____

PERSONAL/ FAMILY HISTORY INFORMATION

In the section below identify if there is a personal family history of any of the following.
If yes, please indicate the family member's relationship to you in the space provided (e.g., self, father, grandmother, uncle, etc.).

Please circle yes or no for each descriptor. If you circle yes, please list "self" or the family member(s) next to the descriptor.

Frequent Physical Ailments	yes / no
Alcohol/Substance Abuse	yes / no
Extreme anxiety	yes / no
Extreme depressed mood	yes / no
Wild mood swings	yes / no
Hyperactivity	yes / no
Domestic violence	yes / no
Trauma history	yes / no
Eating Disorders	yes / no
Obsessive Compulsive Behavior	yes / no
Schizophrenia	yes / no
Suicide or Attempts	yes/ no

Other:

Adoption or foster family history:

RELATIONSHIPS

If you are currently in a romantic relationship, please respond to the following questions.

On a scale from 1 to 10 (with 10 being the highest rating), how would you rate the quality of your relationship? ____

What would you describe as the biggest strengths in your relationship?

What would you describe as the relative weaknesses or problems in your relationship?

ADDITIONAL INFORMATION

What do you consider to be some of your own personal strengths?

What do you consider to be some of your personal weaknesses?

List your goals for therapy:

What indicators will show that your therapy has been successful?

Is there anything else you would like me to know about you?