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 in writing.

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 child) (Phone number)

_____
(Alternate phone number)

Parents' Relationship Status:

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

Insurance carrier's date of birth: _____ co-pay for therapy: $ _____ deductable? _____ Insurance carrier's place of employment:_____

Insurance carrier's policy ID #: _____ Group ID #: _____

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

YOUR CHILD'S HEALTH

Primary care physician: _____ Phone Number:_____

Physician's Address:

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

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

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

Is your child currently taking psychiatric medication?

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

Is your child 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._____

Is your child currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

___No ___Yes If yes, where and for what reason:

_____

_____

Has your child ever seen another therapist?

___No ___Yes If yes, for what and why did the visits stop?

_____

_____

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

_____

_____

_____

FOR EACH PARENT: (to distinguish your responses, please initial your reply.)
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 and your family members regarding:

	SELF	**SPOUSE**	**CHILD**
a. your eating habits	a. _____	a. _____	a. _____
b. your ability to sleep through the night	b. _____	b. _____	b. _____
c. getting regular exercise	c. _____	c. _____	c. _____
d. your physical health	d. _____	d. _____	d. _____
e. your relationships with family members	e. _____	e. _____	e. _____

f.	your ability to deal with stress	f. _____	f. _____	f. _____
g.	your self esteem and confidence	g.	g.	g.
	--related to your body	_____	_____	_____
	--related to your mind/ spirit	_____	_____	_____
h.	your ability to seek emotional support	h.	h.	h.
	from--- friends	_____	_____	_____
	-- others:	_____	_____	_____

EACH FAMILY MEMBER SHOULD COMPLETE THIS PAGE.
Name of person who completed this page: _____

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 <u>in your body</u>? What internal physical reaction(s) do you have or notice?

b. What is your
--typical <u>emotional</u> reaction (feelings)?

--behavioral reaction?

c. How would <u>others</u> 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 FOR YOU AND YOUR CHILD

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 that still impact you, your family or your child today: (we will discuss in further detail in sessions)

FOR BOTH PARENTS: RESOURCES (To distinguish your responses, please initial your reply.)

Overall, what human resources 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: Other: (list)

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

Exercise prayer/spiritual meditation alcohol recreational drugs

Others: _____

FOR EACH PARENT: Please complete separately. <u>Your name</u>: _____

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:	
Other:	

FOR EACH PARENT: Please complete separately. <u>Your name</u>: _____

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 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?