Name:

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Marriage and Family Therapy

Pre-Intake Client Information

Note: Some of the questions in this are about sensitive information. If you find questions that are difficult for you to answer, it is up to you whether you answer them. Whether you answer will not affect the treatment available to you. Also, feel free to add in comments or additional information as you see fit.

Date: ____________

Client Name, including other participants:	Date of birth/relationship to you:
You: ________________________	______________________________
____________________________	______________________________
____________________________	______________________________
____________________________	______________________________
____________________________	______________________________

Address:

Telephone numbers:

Parent/Guardian (if under 18): ______________________________

What brings you to therapy (summarize)?

Please describe the history of this(these) problem(s), including what you believe may have started it or made it worse:

Do you have a history of mental illness? If yes, please describe:

How have you handled major stressors in the past?

Name:

Mark and describe symptoms below that apply to you:

Behavior management:

- Impulsive behavior
- Hyperactivity
- Oppositional behavior
- Violent/aggressive behavior
- Runs off/runs away
- Other:

Activities of daily living:

- Appetite problems/eating disturbance
- Difficulty with sleep
- Difficulty concentrating
- Decreased energy
- Anhedonia (not wanting to do things you usually want to do)
- Not able to work/attend school
- Not able to maintain personal hygiene
- Social withdrawal
- Panic attacks
- Other

Other symptoms:

- Elevated mood (that is problematic or concerning)
- Depressed mood
- Grief
- Hopelessness
- Worthlessness
- Guilt
- Anxiety
- Obsessions/compulsions
- Irritability
- Disruptions of thought process/content
- Physical health complaints that might be related to depression, anxiety or similar conditions
- Nightmares or flashbacks (feeling like you are back in the incident) of a traumatic event
- Other

Other:

- Any thoughts of harming or killing yourself (describe if yes)?
- Any thoughts of seriously harming or killing someone else (describe if yes)?
- Violence/aggression
- Substance abuse
- Do you ever hear or see things that are not really there (describe if yes)?
- Do you feel paranoid (describe if yes)?
- Do you ever ‘lose’ chunks of time?

Anything else:

Name:

In close relationships it is common to have disagreements from time to time. These disagreements show themselves in a number of ways. During a disagreement in the past year:

1) Has anyone close to you made you feel unsafe?

2) Has anyone close to you insulted you frequently, isolated you from friends or family, frequently embarrassed you, or withheld financial resources, food, medication, shelter or any other basic needs?

3) Have you been pushed, grabbed, shoved, or slapped?

4) Have you been kicked, bit, strangled, or hit with a fist?

5) Has anyone close to you forced you to participate in sexual activities against your will?

6) Have you physically hurt anyone close to you in any of the ways mentioned above?

7) Have any of these occurred previous to the last year?

8) Have you ever had someone not necessarily close to you force you to participate in sexual activities against your will?

Any other information you would like to add to your answers above?

Have you ever experienced something traumatic for you? If yes, how does this impact you now? Please give a very brief description (if comfortable):

Family and Significant Relationships – Please discuss who you see as your primary social supports:

Is there any history of mental illness in your family? If yes, please describe:

Is there any history of substance abuse in your family? If yes, please describe:

Is there any history of suicide or suicide attempts in your family? If yes, please describe:

Please describe your developmental history, including prenatal exposure to alcohol, tobacco, or other drugs:

Name:

Please describe your education and work experience (including military):

Have you had or are you currently having any legal involvement? If yes, please describe:

Please describe any important cultural, linguistic, or religious factors in your life:

Please describe any past treatment you have had for mental illness, relationship discord, or substance abuse (include inpatient, outpatient, detox, dates, etc.):

Substance use/abuse:

Substance	Age at first use	How much/often	Last Use	Method of Use
Alcohol				
Cocaine/crack				
Heroin				
Opiates (oxycontin/percocet)				
Hallucinogens				
Amphetamines/meth				
Benzodiazapines/Klonopin/Xanax				
Ecstacy/Rohipnol/Ketamine				
Inhalants				
Tobacco				
Over the counter meds (abused)				
Other:				

Current use (alcohol, tobacco, or other drugs; how much/often/plan to quit/setting):

What are the benefits and disadvantages to your use?

Name:

Please answer the following CAGE questions regarding your alcohol use:

C: Have you ever attempted to *cut down* on your use?	Yes / no
A: Are you ever *annoyed* at other's comments about your use?	Yes / no
G: Do you ever feel *guilty* about your use or regret things done while using?	Yes / no
E: Have you ever had an *eye opener*? (used alcohol first thing in the morning)	Yes / no

For those using illegal drugs or feel you might have a problem with your alcohol or tobacco use:

Current health problems related to use:

Self perception of use (chronic, periodic, heavy, vague, social, remorse, etc.):

Current symptoms:

- Cravings
- Feeling unable to stop using despite wanting to stop
- Feel like you need more of the substance to reach the same high
- Withdrawal symptoms
- Use is a central activity in your life
- You uses substance to escape troubles or self-medicate
- You uses to build confidence
- Other

Problems related to use, note past or current (current within one year):

- Hangovers
- Vomiting/Nausea
- Headaches
- Blackouts
- Passing out
- Convulsions/seizures
- Memory loss
- Social impairment (loss of friendships/relationships)
- Illegal or antisocial behaviors
- Weight changes
- Absence from work or school
- Suspensions from work or school
- Personality changes
- Aggression/violence
- Accidents
- Jail/protective custody
- Medical excuses
- Fired from a job
- Economic problems
- Marriage/family deterioration
- Separation/divorce
- Other

Arrests/court involvement related to substances (possession, distribution, etc.):

Have you ever driven drunk? Ever had a ticket for driving drunk?

Everyone, please answer: Are you willing to stop using alcohol and/or mind altering substances during treatment? If no, discuss:

Name:

Physical Health / Medical Information:

Primary Care Physician: ______________________ Telephone Number: ________________

Date of most recent physical: ______________ Date of next PCP appt: _____________

Please describe any current physical health conditions:

List any allergies you have:

Please describe any history of operations/surgical procedures/ other major medical procedures:

Please describe current or previous pregnancies (including miscarriages/abortions):

Please describe any history of (or current) problematic eating patterns:

Current Medications (circle): None Psychotropic Medical Over the Counter

Do you take them as prescribed? Yes / No

Prescribing physician(s): ____

List current medications:

Name	Dose/frequency	Start date	Side effects	What it is for

How effective is current medication? Please particularly describe effectiveness of any psychotropic medications:

Any other medical information: