INTAKE INFORMATION

Name_____

Briefly state your reasons for seeking treatment at this time (use the back of this page, if needed):_____

_____

_____

_____

FAMILY INFORMATION:

Current Marital Status:

___ single ___married ___separated ___divorced ___widowed

How many times have you been married? ____

If currently married, Name of spouse _____

Age of spouse_____ Occupation of spouse _____

MARITAL HISTORY:

First Marriage: How old were you when you first married? ____

How long have you been (or were you) married? ____

If divorced, how long have you been divorced? _____

Who initiated the divorce _____

Second Marriage:How long have you been (or were you) married? ____

If divorced, how long have you been divorced? _____

Who initiated the divorce _____

Third Marriage:How long have you been (or were you) married? ____

If divorced, how long have you been divorced? _____

Who initiated the divorce _____

CHILDREN:

Number of children and their ages: _____

Number of step-children and their ages: _____

FAMILY OF ORIGIN:

Father: ___living ___deceased

His age: ____ His age at death: ____Your age at his death: ___

Three words to describe my father: _____, _____, _____

Mother:: __living __deceased

Her age: ____Her age at death: ____Your age at her death: ____

Three words to describe my mother: _____, _____, _____

Siblings: Number of full siblings and their ages _____

Number of step-siblings and their ages _____

Number of half-siblings and their ages _____

Do you remember being frightened of your father? ___yes ___no

Do you remember being frightened of your mother? ___yes ___no

Do you remember your mother being frightened of your father? ___yes ___no

Do you remember your father being frightened of your mother? ___yes ___no

Please give a brief description of your childhood (use the back of this page, if needed):_____

_____

_____

EDUCATION:

Please list your highest level of education (High School, Trade School, College, etc).

_____

Current occupation _____ Years at present position _____

PAST TREATMENT HISTORY:

Have you ever been in therapy before? ___Yes ___No

Therapist(s) and approximate dates of treatment:

_____

_____

_____

What was helpful about therapy?

_____

_____

_____

What could have been more helpful?

_____

_____

_____

Describe any trauma history _____

_____

_____

Describe any history of suicidal thoughts or attempts

_____

_____

_____

Describe any history of eating disordered behavior

_____

_____

_____

Have you every been hospitalized for mental health reasons? ___yes ___no

Please list dates, places and reasons for hospitalization:

_____

_____

_____

Does anyone in your family have a history of emotional problems? ___yes ___no

Who has the difficulties and what was/is their problem?

_____

_____

_____

Medical History:Illnesses or medical conditions:

_____

_____

_____

Please list the medications you are taking and dosages (prescription and over the counter):

_____

_____

_____

SUBSTANCE USE HISTORY:

Have you ever been treated for a substance abuse problem? ___yes ___no

Please list where you were treated and when: _____

Do you drink alcohol? ___yes ___no How often? _____

When you drink, what do you usually drink, and how much do you drink?

_____

Do you use street drugs? ___yes ___no What kind and how often?

_____

Do you smoke cigarettes? ___yes ___no. How much do you smoke?

_____

Does anyone in your family have a history of substance abuse problems? __yes ___no

Who has the difficulties and what was/is their problem? _____

_____

MILITARY HISTORY:

Have you ever served in the military? ___yes ___no. What branch? _____

Dates of service: _____ Type of discharge: _____

Where were you stationed? _____

LEGAL HISTORY:

Check any that apply: ___divorce ___drinking or drug related arrest ___criminal ___automobile related ____protective services ___custody ___adoption ___personal protection order ___other (describe) _____

Would you consider yourself, spouse, mother or father to be an alcoholic?

Self: ___yes ___no Spouse ___yes ___no Mother ___yes ___no Father ___yes ___no

Would you consider yourself, spouse, mother or father to be an drug addict?

Self: ___yes ___no Spouse ___yes ___no Mother ___yes ___no Father ___yes ___no

Have you ever been raped or sexually assaulted? ___yes ___no.

By whom, and when did this occur?

_____

_____

_____

Have you ever had sexual contact with a relative? ___yes ___no.

With whom, and at what ages?

_____

_____

_____

Were you abused as a child? ___yes ___no.

By whom, and at what ages?

_____

_____

_____

Have you ever been abusive toward another adult or child? ___yes ___no.

Toward whom, and when?

_____

_____

_____

Has anyone in your family ever attempted or committed suicide? ___yes ___no.

Who and when?

_____

_____

_____

Are your parents divorced? __yes ___no. How old were you when they divorced? ____

Please list your hobbies and activities:

_____

_____

_____

What have you done to try to cope with your problems?

_____

_____

_____

Please list the people in your life whom you consider to be supportive.

_____

_____

_____

Thank you for taking the time to complete this form.