# 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:

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.