

INTAKE INFORMATION

Name _____

Briefly state your reasons for seeking treatment at this time (use an additional 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 an additional 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 a 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.