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Licensed Marriage and Family Therapist
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Patient Intake

Please complete this questionnaire as completely as you can.

Name ______________________________ Date _______________ SS# _____________

Address __________________________________ Home Phone ____________________

City _________________________ Zip _______ Work Phone ____________________

Cell Phone ______________________________

Birth date/place ____________________ Age _____ Marital Status: S ___ M ___ D ___

Car (make)/year _________________________ Car license plate # _________________

Current Living Situation (married, living with spouse)

____

____

____

Name of spouse _______________________ Age _____ Occupation _______________

Describe your relationship with your spouse (significant other)

____

____

____

____

Names & Ages of Children ____

____

(Over)

Your Employer ____

Name Address

Your Occupation
____

Physician's Name _________________________ Phone ____________________

Current Health Problems ____

____

Current Medications ____

Have you been in Counseling/Therapy in the past? __________ Yes _________ No

If Yes, Date ____________________ Duration __________________________

____

List previous therapist's name and location
____

Do you feel that therapy helped you? ___________________ Yes ___________ No

____

____

How ? ____

Reason for Termination ____

Psychosocial

Name(s) and age(s) of siblings: ____

(over)
Describe your relationship with each of your siblings: __________________________

Mother, stepmother, father's spouse, father, stepfather, mother's spouse, etc. – Describe your relationship with each: ____

What has brought you into counseling at this time?

____

How do you see the counselor's role in helping you? ___________________________

____

Referred by whom? ____

Highest grade/degree ____

Person and phone number to call in emergency ______________________________

Past marriage(s), years together, name, statement about nature of relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile, etc. __________

Past/present drug/alcohol use/abuse (AA, NA treatment) _________________________

Suicide attempts (or) violent behavior (describe ages, circumstances, how, etc.. _____

Family medical history (describe any illness that runs in the family, cancer, epilepsy, etc.)