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Connected Marriage and Family Therapy
Intake Assessment Form

Welcome! These forms will give you the chance to describe your situation and history. Please fill them out as completely as possible and have them ready before your first counseling session.

CLIENT INFORMATION

Name: ______________________________

Date of Birth: ______________ Age: ______________ ()Male () Female

Address: ______________________________

Occupation: ______________________________

Employer: ______________________________

School (if student): ______________________________

Phone (h): ______________________Messages ok at home? () Yes () No

Phone (cell): ______________________Messages ok on cell? () Yes () No

Phone (w): ______________________ Messages ok at work? () Yes () No

(Note: I cannot guarantee the confidentiality of cell conversations.)

Email: ______________________Emails ok? () Yes () No

(Note: I cannot guarantee the confidentiality of email.)

How did you find out about my services? ______________________

If referred by a person, may I have your permission to thank him/her? () Yes () No

Religious Affiliation: ______________________________

Ethnic/Cultural Heritage: ______________________________

MARITAL STATUS

() Single () Married (legally) () Divorced Total # of marriages:____________ () Cohabitating () Divorce in process () Separated () Widowed () Other:______________Assessment of current relationship (if applicable): () Good () Fair ()Poor

Comments: ______________________________

____

____

FAMILY INFORMATION

Relationship	Name	Age	Sex	Type(bio, step, etc.)	Living with you?
Mother					() Yes () No
Father					() Yes () No
Spouse/SO					() Yes () No
Children/					() Yes () No
Siblings					() Yes () No
					() Yes () No
					() Yes () No

(Continue on back if needed)

EDUCATION

Fill in all that apply: Years of education: ____________________________ Currently enrolled: () Yes () No High School grad/GED _________College ________Vocational _________Graduate School________________________

Other training:____

Special circumstances:____

MILITARY

Military experience? () Yes () No Combat experience? () Yes () No

Where: ____ Branch: ___________________________________

Type of discharge: ___________________________________ Length of service: ___________________________

Rank at discharge: ____

PERSONAL STRENGTHS

What do you do well and what activities do you enjoy? ____

____

What personal qualities would others say you have? ____

____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) ____

____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? () Yes () No

Approximate Dates of Counseling: ____

For what reason? ____

What did you find most helpful in therapy? ____

What did you find least helpful in therapy? ______________________________

Have you used psychiatric services? () Yes () No Was it helpful? () Yes () No

Please describe. ______________________________

____

Have you taken medication for a mental health concern? () Yes () No

Name of medication	Dates Taken	Helpful?(Y/N)

Do you have other medical concerns or previous hospitalizations? Please describe. ______________________________

____

Have you ever felt like hurting yourself? Please describe. ______________________________

____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.______________________________

____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you/your child/adolescent desire to have counseling? ______________________________

____

What would you like to see happen as a result of counseling? ______________________________

____

What is most concerning right now? ______________________________

____

CURRENT FAMILY AND SIGNIFICANT RELATIONSHIPS

Strengths/supports (relationships, support groups, etc.): ______________________________

____

Stressors/problems: ______________________________

____

Recent changes: ______________________________

____

Changes desired: ______________________________

____

FAMILY CONCERNS

Please check any family concerns that you are having. () Fighting () Feeling Distant () Loss of fun () Lack of honesty () Physical fights () Education problems () Money () Disagreeing about Relatives () Disagreeing about Friends () Alcohol Use () Drug Use () Infidelity () Other_____________

Other Comments: ____

____

SUBSTANCE USE

Please check substances you use on a weekly/monthly (circle) basis: Alcohol _______ x per week / month Marijuana _______ x per week / month Cocaine _______ x per week / month Heroine _______ x per week / month Meth _______ x per week / month Ecstasy _______ x per week / month

Check all that apply: ______ I believe that my substance use may be a problem. ______ I believe that my partner's substance use may be a problem.

INDIVIDUAL CONCERNS

Please check any personal concerns that you are having: () Sadness () Crying () Irritability () Loss of pleasure () Sleep problems () Eating problems () Hopelessness () Guilt () Mood swings () Fear

() Nightmares () Flashbacks () Obsessions () Anxiety () Panic () Suicidal thoughts () Suicidal acts () Hurting self () Hurting others () Anger/Rage () Abuse (childhood) () Abuse (adult) () Distractible () Hearing things () Seeing things () Loneliness () Grief/loss () Work issues () Spirituality issues () Alcohol Use () Another's Alcohol Use () Drug Use () Another's Drug Use () Other: __________________

Comments:____

Is there anything else you would like to share: ____

____

I understand that by signing below, I am stating the above information is true.

_______________________________________ _______________________

Client Signature Date

_______________________________________ _______________________

Parent (or guardian) Signature Date