Client Information Form ** Adult Form

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Marriage and Family Therapist

Your Name:_____ Today's Date:_____

This form is intended to save both you and your intake interviewer time and is in the interest of providing you with the best service possible. All information on this form is considered confidential. If you do not wish to answer a question, please write "Do not care to answer" after the question.

PERSONAL DATA

Address: _____

_____

Age: _____ Birthdate: _____Ethnicity: _____

Social Security #: _____

Telephone:
(Home): _____Best time to call:_____May I leave a message?_____

(Work): _____ Best time to call:_____May I leave a message?_____

(Cell): _____ Best time to call:_____May I leave a message?_____

Person To Be Contacted In Case of Emergency:

Name:_____Relationship to you: _____

Address: _____

Telephone: _____

What is your main concern that brings you to therapy?

_____

_____

Approximately how long has this concern(s) been bothering you?

_____

MEDICAL INFORMATION

Current Physician: _____ Last Visit: _____

Address: _____Phone: _____

Other physician(s):_____Last Visit: _____

Address: _____Phone: _____

Current Medical Problems: _____

_____

Medications Being Taken: _____

_____

_____

Medical Hospitalizations

Date	*Hospital Name*	*Reason*	*Length of Stay*

History of Other Illnesses

Date	*Nature of Condition*	*Duration*

Please provide any other information you want me to know about your health or medical history

_____

_____

_____

Name and phone of person who referred you (if applicable):_____

FAMILY DATA

Is Father Living? Yes ___ No ___ If yes, Current Age: _____

Residence (City): _____ Occupation: _____

How often do you have contact? _____

If No, His age at death: _____ Your age at his death: _____

Cause of Death: _____

Is Mother Living? Yes ___ No ___ If Yes, Current Age: _____

Residence (City): _____ Occupation: _____

How often do you have contact? _____

If No, Her age at death: _____ Your age at her death: _____

Cause of Death: _____

Brothers and Sisters

Name *Age* *Occupation* *Residence* *Contact how often?*

_____

_____

_____

Marital Status:

___ Married ___ Single How Long ?: _____

___ Divorced ___ Cohabitating Previous Marriages ?: _____

___ Separated ___ Widowed How Long Since Divorce?: _____

List below the people living with you currently:

Name *Relationship* *Age* *Occupation*

_____

_____

_____

_____

EDUCATIONAL AND OCCUPATIONAL HISTORY

Highest Grade Completed: ____ Elementary (1-6)
____ Junior High (7-9)
____ Senior High (10-12) Diploma? ____
____ College (13-16) Degree? ____

Other Professional, Technical or Vocational Training:

_____

_____

Currently in school? _____ School/ Location: _____

Current and Previous Jobs:

Job Title	*Employer Name & City*	*Dates / Duration*

_____

_____

Current Annual Family Income: _____

INSURANCE INFORMATION

Primary Insurance company_____ ID #_____

Policy number _____Group number _____

Subscriber name _____ Subscriber SS#_____

Subscriber's relationship to client: Self___ Spouse ___ Parent___ Subscriber birthdate_____

Secondary Insurance company_____ ID #_____

Policy number _____Group number _____

Subscriber name _____ Subscriber SS#_____

Subscriber's relationship to client: Self___ Spouse ___ Parent___ Subscriber birthdate_____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of governmental benefits either to myself or to the party who accepts assignment.

Signature_____Date_____/_____/____

I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

Signature_____Date_____/_____/____

PSYCHIATRIC HISTORY

Have you ever received psychiatric or psychological treatment of any kind before? Y___ N____

If you checked "Yes" to the above question, please answer the following:

What type of care did you receive? Inpatient ____ Outpatient _____ Both ____

Did your doctor prescribe medication at the time? Y___ N ___ Not Applicable___

If yes, what was prescribed? (include dosages and frequency, if possible):

_____

_____

_____

Habits	*Amount Currently Using*	*Most Ever Used*
Coffee (cups per day)		
Cigarettes (packs per day)		
Alcohol (drinks per day)		

Have you ever abused drugs or alcohol?

If yes, please describe:

Substances	Amount	Frequency	When? (First use, Last use)

Please indicate with an X how your problems are affecting the following areas:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/relationship						
Family						
Job/School performance						
Friends						
Hobbies						
Financial situation						
Physical health						
Anxiety level/Nerves						
Mood						
Sexual functioning						
Ability to communicate						
Ability to control your temper						

Please check boxes to indicate which of the following areas are current problems for you and reasons for counseling. Place <u>TWO</u> check marks to indicate the most important reason(s).

____ Feeling nervous or anxious

____ Under Pressure & feeling stressed

____ Needing to learn to relax

____ Afraid of being on your own

____ Feeling angry much of the time

____ Difficulty expressing emotions

____ Feeling inferior to others

____ Lacking self confidence

____ Feeling down or unhappy

____ Feeling lonely

____ Experiencing guilt feelings

____ Feeling down on yourself

____ Thoughts of taking own life

____ Concerns about emotional stability

____ Feeling cut-off from your emotions

____ Wondering "Who I Am"

____ Having difficulty being honest /open

____ Difficulty making decisions

____ Feeling confused much of the time

____ Difficulty controlling your thoughts

____ Being suspicious of others

____ Getting into trouble

____ Difficulty with school or work

____ Concerns about finances

____ Trouble communicating sometimes

____ Having a hard time making friends

____ Having a hard time keeping friends

____ Feeling pressured by others

____ Feeling controlled/manipulated

____ Pre-marital counseling

____ Marital Problems

____ Family difficulties

____ Difficulties with children

____ Break-up of relationship

____ Difficulties in sexual relationships

____ Feeling guilty about sexual activity

____ Feeling conflicted about attraction to members of same sex

____ Confusion about sexual orientation

____ Feelings related to having been molested

____ Concerns about physical health

____ Feeling fat even if weight is below average

____ Difficulties with weight control

____ Use/Abuse of alcohol or drugs

<u>Additional Concerns</u> (if not covered above):

_____

_____