Dana Falls, Marriage and Family Therapist
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Today's
Date:_____

First Name:_____ Last Name _____

Age:_____ Date of Birth:_____

Phone:_____

Address:_____

Email Address: _____

City: _____Zip:_____

Referred by?_____

Gender ☐ Male ☐ Female Orientation: (circle) S L B G T Q I A

Ethnicity:_____ Religion:_____

Highest grade/degree:_____

Occupation:_____

Employer_____

Source of Income:

Employment___ Unemployment___ Spouse/Significant other___
Social Security___ Short Term Disability___ Other_____.

Relationship Status

Are you: Married _____Partnered _____ Single _____Separated_____
Divorced _____ Widowed _____

Are you presently married (circle) **Y N** or involved in a relationship? (circle) **Y N**
Name of individual who you identify as your significant other? _____.
If "yes" how would you describe your current level of satisfaction with the relationship? _____

_____.

Have you been married previously? If yes, when? _____

If married or in a relationship, rate your level of contentment/happiness/satisfaction in the relationship on a scale of 1 to 10. (1=very happy, 10=very unhappy.) Briefly explain the rating you give in the space provided._____

_____

_____.

On a 1 to 10 scale (1=very happy, 10=very unhappy) describe your level of commitment to your relationship. Briefly explain_____

_____

Current living situation? (spouse, partner, children, relatives, roommates etc.) names, ages, occupation, and a brief comment about your relationship e.g., close, distant, supportive, conflictual

1._____
2._____
3._____
4._____
5._____

Family Information

Were you adopted, Y N. If yes, at what age were you adopted?_____

Family of Origin: (please list parents/step-parents, siblings name and ages. If deceased, year/cause of death. Comment briefly on your relationship to each.

1._____
2._____
3._____
4._____
5._____
6._____

If parents divorced: Your age at the time:_____. How did it affect you?

_____
_____
_____

Reason(s) for seeking help at this time?

_____
_____

_____
_____

What have you tried to help with the above problem(s)?

_____
_____
_____
_____

What are your Strengths, Interests, Abilities, Friendships, Supports? (please describe)

_____

_____

_____

Physical Fitness

Do you have physical activities that you participate in for your health? Please describe what kind of activity, how many days a week, for what duration and how important is this part of your life to you.

_____

_____

_____

Spiritual/Cultural (Optional)

Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:_____

_____

Do any of the above religious, cultural or spiritual issues contribute to your current concerns? If so please describe:_____

_____

_____

What are your hopes/dreams? _____
_____
_____

Medical Information

Medical Doctors: (name and phone)
_____

Prior or Current Medications including psychiatric? ☐ Yes ☐ No (If yes, please list type, medication name, dosage, and side effects) Example: "antidepressant (type) Zoloft (medication name), 50mg once daily (dose), insomnia (side effect)

_____

_____

_____

_____

Past/Present Medical Care (major medical problems, surgeries, accidents, illness):
_____
_____

Prior Outpatient Psychotherapy? ☐ Yes ☐ No (Please provide names and dates if known, initial reason for therapy, and how it was or was not helpful)
_____

_____

Prior Inpatient Psychiatric or Substance Abuse hospitalization? Please Describe: Was it voluntary? Where? Length of stay, Was it helpful or not?_____

_____

_____

Military History

Are you currently on active duty? (circle) **Y N.** Have you ever served in the military? _____If yes, length of time served_____.
Were you ever deployed? (circle) Y N.

Legal History

Have you been ordered by the court to participate in this therapy? (circle) Y N.
If yes, you may be required to supply supporting documentation such as copy of the court order.

Are you currently involved in any kind of litigation or legal dispute? Y N.
If yes, please explain (ie, custody dispute, dissolution proceedings, etc.):

Substance Use

Do you have concerns about your alcohol or drugs? ☐ Yes ☐ No

If you drink alcohol, please indicate current use (one drink equals one shot of liquor, 1 beer, or one glass of wine). Average number of drinks a week?_____.

Do you use drugs including marijuana? ☐Yes ☐No (please check one)
If yes, what drugs?_____

How much?_____How often?_____

If you have or have had concerns about your relationship to alcohol or drugs, what solutions or treatments have you attempted? Example, outpatient or inpatient treatment, 12-step programs, Refuge Recovery, Sober Living, Stopped on your own, other _____

Additional Information

Please let me know of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any significant life events.

_____

Thank you for taking the time to fill out this questionnaire!

Client Signature_____ Date_____