Family System Intake
Adult

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This form requests information about your needs and informs you of my services and policies. Please take a few moments to complete this form. The questions on the following pages are designed to help me best meet your treatment needs.

Client Name ____ **Birth date** ________________

Address ____ **Age** _______

City, State, Zip ____ **Gender Female Male**

Relationship Status: Single Married Domestic Partner Separated Divorced Widowed

Primary Care Physician __________________________ **(____)** ______________________________
Phone

Your Phone # (____) ___________________________ **(____)** ________________________________
Home: OK to contact there? Y N **Work: OK to contact there? Y N**
OK to leave detailed msg.? Y N **OK to leave detailed msg.? Y N**

Cell#: (____)________________________

Email: ____

Please list all persons living in the household:

Name/age	Relationship	Characteristics of interactions with identified client or family as a whole. (ex. Fight, get along well, ignores, blames, etc.)

1. Please describe your reason(s) for seeking treatment. If there is an event which triggered your decision to seek treatment now, please list the event.

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2. Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Effect	Little Effect	Some Effect	Much Effect	Severe Effect	N/A
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety level/nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping habits	1	2	3	4	5	N/A
Sexual functioning	1	2	3	4	5	N/A
Alcohol/Drug usage	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control temper	1	2	3	4	5	N/A
Suicidal thoughts/behavior	1	2	3	4	5	N/A
Self-mutilation	1	2	3	4	5	N/A

3. What result(s) do you expect from treatment?

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4. Medications: (please list all psychoactive medications you have used)

Med./Dose	Past/ current	Effectiveness/problems	Prescribing Physician

5. Medication allergies?____

6. Please list any over the counter medications you take: ___________________________________

7. Please describe your use of the following substances:

Alcohol: __No use __Past only __Minimal __Occasional __Often __Problematic

Nicotine: __No use __Past only __Minimal __Occasional __Often __Problematic

Marijuana: __No use __Past only __Minimal __Occasional __Often __Problematic

Cocaine: __No use __Past only __Minimal __Occasional __Often __Problematic

Meth: __No use __Past only __Minimal __Occasional __Often __Problematic

Heroin: __No use __Past only __Minimal __Occasional __Often __Problematic

Rx abuse: __No use __Past only __Minimal __Occasional __Often __Problematic

8. Are there any cultural, ethnic or religious factors or needs related to treatment? No Yes:

____

9. Please list strengths and resources you have that positively impact coping and ability to overcome adversity: ____

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PLEASE LIST PREVIOUS OR CURRENT THERAPIES AND/OR COUNSELING THAT YOU HAVE RECEIVED.

THERAPIST NAME/PHONE	TREATMENT ISSUE	OUTCOME/ EFFECTIVENESS	DATES

ARE THERE AREAS OF CONCERN THAT WERE NOT COVERED IN THIS QUESTIONNAIRE THAT YOU FEEL ARE IMPORTANT TO BE AWARE OF SUCH AS FAMILY ISSUES, RECENT SIGNIFICANT EVENTS, ETC.?

TREATMENT PHILOSOPHY

I believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal in a time-efficient manner.

Although strategies and techniques vary from one therapist to another, basic techniques are established by professional practices. I do not employ techniques that are outside the mainstream of established therapy methods. If you ever have any questions about the nature of the treatment or anything else about your care, please don’t hesitate to ask.

Typical goals of therapy are to:

* **Help you clarify problems and goals**
* **Help you see problems from a different point of view**
* **Help you discover new ways of solving old problems**
* **Encourage you to change certain behaviors or attitudes**
* **Enhance your self-respect**
* **Help you to live a healthier and happier life**

I follow the Code of Ethics of the American Association for Marriage and Family Therapy. This is the primary professional organization which promotes the profession of marriage and family therapy.

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EMERGENCY PROCEDURES

If you need to contact me, leave a message according to the instructions on my voicemail and your call will be returned. If an emergency situation arises, follow the emergency procedures mentioned on my voicemail and I will be contacted. I will return your call. Please use this for true emergencies and know that there may be a charge for lengthy telephone consultations. You may also always call 911 and speak to your local police.

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out mental health examinations, treatment, and/or diagnostic procedures, which now or during my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I understand that the therapist or client(s) can terminate therapy at any time by giving notice personally, in writing or over the phone.

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Signature **Date**