

Family System Intake
Adult

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Client Name _____ Birth date _____

Address _____ Age _____

City, State, Zip _____ Gender Female Male

Relationship Status: Single Married Domestic Partner Separated Divorced Widowed

Your Phone # (____) _____ (____) _____

Home: OK to contact there? Y N
OK to leave detailed msg.? Y N

Work: OK to contact there? 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.) |
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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 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?

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

| Med./Dose | Past/ current | Effectiveness/problems | Prescribing Physician |
|-----------|------------------|------------------------|-----------------------|
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5. Please list any over the counter medications you take: _____

6. 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

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

8. Please list your strengths and resources that positively impact coping and ability to overcome adversity: _____

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

| THERAPIST NAME/PHONE | TREATMENT ISSUE | OUTCOME/ EFFECTIVENESS | DATES |
|----------------------|-----------------|---------------------------|-------|
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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.?

EMERGENCY PROCEDURES

If you need to contact me, leave a voicemail message or send me an email. If an emergency situation arises, please call my cell at 720-270-2058. 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. A list of helpful resources, phone numbers and websites is available on the 'Resource' page of my website at adamwoodruff.net.

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.

Signature

Date