Rebecca Toner, M.A., MFT

Licensed Marriage and Family Therapist
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Adult Intake Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No
Cell/Other Phone: _____ May I leave a message? □Yes □No

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Do you have medical insurance? _____If so, who is the provider? _____

Please provide emergency contact information (name, address, phone number(s) :

_____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed
Please list any children/age: _____

Briefly, what is the main problem for which you are seeking my assistance? (i.e., depression, anxiety, relationship problems, stress, parenting difficulties, et

_____

_____

Have you previously been in counseling before?
□ No □ Yes
If so, with whom? Was it helpful? Why or why not?

HEALTH AND SOCIAL INFORMATION:

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

_____

2. Are you currently taking any prescription medication?
□ No □ Yes If yes, please list:_____

3. Have you ever been prescribed psychiatric medication?
□ No □ Yes
Please list and provide dates prescribed:

_____

_____

4. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:
_____

5. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

6. Please list any difficulties you experience with your appetite or eating patterns:

_____

7. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes
If yes, for approximately how long? _____
8. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes
If yes, when did you begin experiencing this? _____
9. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe? _____
10. Have you ever thought about hurting yourself? □ No □ Yes
11. Have you ever tried to commit suicide? □ No □ Yes
12. Have you ever been hospitalized for psychiatric reasons? □ No □ Yes
13. Do you drink alcohol? □ No □ Yes If yes, how much per week?_____
14. Do you engage in recreational drug use? □ Daily □ Weekly □ Monthly□ Infrequently □ Never
15. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____
On a scale of 1-10 (10 being the best), how would you rate your relationship? _____
16. What significant life changes or stressful events have you experienced recently?

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandfather, aunt, etc.).

Please Circle (yes or no)	**List Family Member(s)**
Alcohol/Substance Abuse yes/no	_____
Anxiety yes/no	_____
Depression yes/no	_____
Domestic Violence yes/no	_____
Eating Disorders yes/no	_____
Obesity yes/no	_____
Obsessive Compulsive Behavior yes/no	_____
Schizophrenia yes/no	_____
Suicide Attempts yes/no	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation?
_____

2. Do you enjoy your work? Is there anything stressful about your current work?
_____

_____

3. What do you consider to be some of your strengths?
_____

_____

4. What are some effective coping strategies that have worked for you?
_____

_____

5. What are some of your goals for therapy?
_____

_____

_____

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

Rebecca Toner, MFT