Kristina Jackson MS LMFT

Marriage and Family Therapy
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INTAKE QUESTIONAIRRE

Name:_____Date of Birth: _____Age: _____

Address: _____City: _____ Zip Code: _____

Telephone: Cell _____ Home _____

Email for billing and scheduling appointments: _____

Referred by: ☐Family ☐Friend ☐Physician ☐School ☐Internet ☐ EFT Directory

Other: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Type of help desired: ☐ Individual Therapy ☐ Couples Therapy ☐ Family Therapy
☐ Child/Adolescent Therapy

Reason(s) for seeking help at this time: _____
_____
_____

How long have you had these symptoms or struggles? _____

What are your goals for therapy at this time? _____
_____
_____

Are you currently under the care of a physician or psychiatrist? ☐ No ☐ Yes

Physician's Name: _____ Phone: _____

Treatment for: _____

Are you currently taking any medication? ☐ No ☐ Yes

Name of Medications Dosage Prescribed by

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any serious medical conditions? No Yes If yes, please include any serious or chronic medical conditions, surgeries and/or accidents: _____

_____

_____

Have you ever attempted suicide? No Yes If yes, include number of attempts, dates and precipitating events. Include any history of suicide or suicidal attempts within your family: _____

_____

_____

Check all item below that apply to current and/or past condition(s):

	Current / Past		Current / Past		Current / Past
Headaches	_____ _____	Dizziness	_____ _____	Stomach problems	_____ _____
Chronic pain	_____ _____	Tremors or tics	_____ _____	Craving drugs	_____ _____
Craving alcohol	_____ _____	Eating problems	_____ _____	Binge eating	_____ _____
Sleep problems	_____ _____	Weight loss	_____ _____	Weight gain/loss	_____ _____
Loss of appetite	_____ _____	Feeling apart from others	_____ _____	Low energy	_____ _____
Can't enjoy life	_____ _____	Thoughts of suicide	_____ _____	Excessive energy	_____ _____
Restlessness	_____ _____	Decreased need for sleep	_____ _____	Mood swings	_____ _____
Feeling wired	_____ _____	Confusion	_____ _____	Elated/euphoric mood	_____ _____
Racing/overflow of thoughts	_____ _____	Excessive spending	_____ _____	Irritable mood	_____ _____
Impulsive behavior	_____ _____	Grandiose thoughts	_____ _____	Anger or explosiveness	_____ _____
Panic Attacks	_____ _____	Fears/phobias	_____ _____	Nightmares	_____ _____
Fears of losing control	_____ _____	Always worried	_____ _____	Concentration problems	_____ _____
Hear voices others don't hear	_____ _____	See things others don't see	_____ _____	Have strange experiences	_____ _____
Feel people plot against you	_____ _____	Constant suspicion	_____ _____	Unusual thoughts	_____ _____
Physical abuse	_____ _____	Sexual abuse	_____ _____	Sexual problems	_____ _____
Relationship problems	_____ _____	Financial problems	_____ _____	Conflict in family	_____ _____
Conflict at work	_____ _____	Spiritual problems	_____ _____	Academic problems	_____ _____
Acculturation problems	_____ _____	Gambling problems	_____ _____	Legal Problems	_____ _____
Someone physically harming you	_____ ____	Thoughts of harming someone	_____ _____	Aggressive behavior	_____ _____

ALCOHOL AND OTHER DRUG USE:

Do you use alcohol? ☐ No Yes ☐

How much per day/week _____ Age you started drinking? _____

Do you use other drugs? ☐ No Yes ☐

What kind? _____ Age you started using? _____

Last drug used (type, amount & when) _____

Do you feel you have a problem with ☐ Alcohol ☐ Other Drugs?

Do others feel you have a problem? ☐ No ☐ Yes Explain _____

_____

_____

Has your drinking or drug use caused problems in the family or in your relationships? No ☐ Yes ☐

Has your drinking or drug use caused problems on your job? No ☐ Yes ☐

Is it difficult for you to stop or control the amount you take? No ☐ Yes ☐

Have you ever been arrested for a DUI or other related offense(s)? No ☐ Yes ☐

Have you or anyone in your family been in a treatment program for substance use? No ☐ Yes ☐

FAMILY DATA:

First Name Age Living? How do/did you get along?

Spouse/Partner: _____

Children: _____

_____

_____

_____

_____

Mother: _____

Stepmother: _____

Father: _____

Stepfather: _____

Siblings: _____

_____

_____

_____

_____

Who is part of your emotional support system? _____

_____

What do you consider to be your strengths? _____

_____

Is there any other information I should know to best serve your counseling needs? _____

_____

_____

Signature: _____ Date: _____