

**Marriage & Family Therapy of Trumbull (MFT3)**  
 2 Corporate Drive, Suite 211 • Trumbull, CT 06611 • 203-416-6008

**CLIENT INTAKE FORM**

Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

**GENERAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May I contact you at home?: Yes No Messages OK?: Yes No

Work Phone: \_\_\_\_\_ May I contact you at work?: Yes No Messages OK?: Yes No

Cell Phone: \_\_\_\_\_ May I contact your cell?: Yes No Messages OK?: Yes No

Marital Status: Single Cohabiting Married Separated Divorced Widowed

Children?: Yes No If yes, custody status: \_\_\_\_\_

Household members: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact's Phone #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Title/Position: \_\_\_\_\_

**Treatment of Minor Child**

Parent or Legal Guardian Name \_\_\_\_\_ I give consent for treatment \_\_\_\_\_ (initial)

Child Name \_\_\_\_\_ Age/Grade \_\_\_\_\_

**SYMPTOM CHECKLIST** (Rate intensity of symptoms currently present)

• **None** = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

• **Moderate** = Significant impact on quality of life / functioning • **Severe** = Profound impact on quality of life / functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed Mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hyperactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite Disturbance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Delusions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep Disturbance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hallucinations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue/Low Energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Aggressive Behaviors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor Concentration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bingeing/Purging	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood Swings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anorexia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Agitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Family Conflict	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elevated Mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Weight Loss/Gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotionality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hopelessness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grief	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social Isolation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sexual Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worthlessness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Phobias	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Panic Attacks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Obsessions/Compulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-Inflicted Wounding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Difficulty Making Friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Difficulty Keeping Friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**PURPOSE FOR VISIT**

What brings you into therapy today? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did the issue arise? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who is supportive of you? Where do you go for help? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PSYCHIATRIC HISTORY**

Prior suicide attempts? Yes No

If yes, when? \_\_\_\_\_

Circumstances that led to the attempt: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current suicidal thoughts? Yes No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you had any prior therapy? Yes No

If yes, when and for how long? \_\_\_\_\_

What was the focus of previous treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Was it helpful? \_\_\_\_\_

Prior hospitalization for mental/emotional problems? Yes No

If yes, please describe (year/duration/reason for hospitalization): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Are you currently taking **any** prescription medication? Yes No

If yes, please provide the following details (*to the best of your ability*):

Medication	Dose	Method	Physician
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are any of these medications for mental/emotional problems? Yes No

Do you have any medical conditions that may affect your treatment? Yes No

Please describe your overall health today: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of last visit to Physician: \_\_\_\_\_

Do you drink alcohol?    Yes    No    If yes, how much do you consume in a week?: \_\_\_\_\_

Do you currently use drugs (street, non-prescription or herbal supplements)?    Yes    No

If yes, please describe your drug use: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION**

What do you consider to be your strengths?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What do you like most about yourself?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What do you consider to be your weaknesses?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**GENOGRAM**

**CLINICAL SUMMARY:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_