

**BROCKPORT
MARRIAGE & FAMILY THERAPY, P.C.**

INTAKE FORM

(Please provide as much detail as possible. This and all information concerning you and your loved ones is kept strictly confidential.)

Full Name of Person Completing Form

Today's Date

How did you hear about Brockport Marriage & Family Therapy?

CONTACT INFORMATION

Home Address:

Street

City State Zip code

Is this address okay for correspondence by mail (Y/N)?

Phone Number: (____) _____

Is this number okay to use for future communications and leaving messages (Y/N)?

Please make sure to leave a number that can be used for future contact.

EMPLOYMENT

Are you currently employed? (Y/N): If so, where are you employed?

What is your job?

How long have you held this position?

If you are not currently employed, are you actively seeking employment?

Please describe:

Is anyone in the family on disability? If so, please explain the nature of the disability:

FAMILY COMPOSITION, CONTINUED

Please list any family members *not* currently residing in your home:

Full Name	Relation to you	Gender (M/F)	Date of birth (dd/mm/yyyy)	Grade/Current School/School District	Place of Residence City, State

PREVIOUS COUNSELING EXPERIENCE

Have you or any of your family members ever received counseling before? Please list any family members who have received counseling services below:

Name of family member	Name of treatment facility	Inpatient/Outpatient/School	From (mm/yy)	To (mm/yy)

Any comments regarding your previous experience of counseling (things that worked, things that didn't work)?

SUBSTANCE ABUSE HISTORY

Have you or any of your family members received treatment for chemical dependency or substance abuse? Please explain:

Are you or any of your family members currently using or abusing alcohol and/or addictive substances (including chewing tobacco, cigarettes, prescription medication)?

MILITARY AFFILIATION

Have you or any of your family members ever been deployed overseas or served in a combat zone?

Please describe:

VIOLENCE IN THE HOME

Have you or any of your family members been engaged in physical and/or verbal abuse in the past six months?

Please describe:

CULTURAL/ETHNIC IDENTITY

How would you describe your family's cultural/ethnic heritage?

Are any languages other than English spoken in the family? *(Please consider including American Sign Language ASL, if applicable.)*

If so, which languages other than English are spoken in the home?

SPIRITUAL/RELIGIOUS AFFILIATION:

Do you or any members of your family practice a faith-based religion or spiritual pursuit?

Please describe:

LEGAL HISTORY

Are you or any of your family members currently experiencing any legal difficulties (PINS, probation, divorce, custody, arrest, etc)?

Please describe:

Is there a history of past legal involvement? Please describe:

MEDICAL HISTORY

Are you or any of your family members currently undergoing treatment or receiving special services for a medical condition? Please describe:

Are you or any of your family members currently taking medication for a psychiatric or behavioral problem? If so, please complete the following:

Name of family member	Medication	Reason prescribed	Dose (total units per day)	Name of prescribing physician	Medication taken since mm/yyyy

PHYSICAL, DEVELOPMENTAL, COGNITIVE, SPEECH CONCERNS

Are you or any of your family members currently receiving treatment or special services for any physical, developmental, cognitive and/or speech concerns (physical therapy, occupational therapy, IEP, etc)? Please describe:

Policy regarding secrets in marriage and family therapy:

Therapy is a journey that invites us to learn new skills and gain new perspectives so that we can build honesty and trust in our relationships. The process takes courage, patience and *openness*. Due to the collaborative nature of marriage and family therapy, it is imperative that the therapist maintain a neutral stance toward couples and families. *This can only be achieved in the absence of secret within the treatment group*. Therefore, please refrain from asking your therapist to keep secrets from other members in treatment. This applies to all forms of communication (verbal, email, phone and written correspondence).

EMERGENCY CONTACT INFORMATION

Please provide an emergency contact should an emergency situation arise during our work together:

First Name Last Name

Street

City State Zip code

Phone Number: (____) _____

Signature of person completing the form

Date