

DEBORAH GROENING, MFT, MARRIAGE & FAMILY THERAPY, INC.

Adult Initial Intake

Client Name: _____ Date: _____

1. Please describe what brings you here and any symptoms that you are currently experiencing.

2. How long have the symptoms been occurring? _____

3. Have there been any major changes at work or at home lately? Yes No If yes please explain:

4. Are you currently receiving any treatment for the symptoms listed above? Yes No

If yes, please explain: _____

Therapist/Physician: _____ Phone: _____

5. Have you received treatment or counseling in the past? Yes No If yes, what were the reason(s)?

Therapist/Physician: _____ Dates seen: _____ Phone: _____

6. List current medical conditions: _____

Physician: _____ Phone: _____ Last visit: _____

7. Are you currently taking medication? Yes No If yes, please explain: _____

Previous prescriptions: _____

8. Have you had any hospitalizations or procedures in the past? Yes No If yes, please explain:

9. Are you currently experiencing any thoughts of self-harm or suicide? Yes No If yes, please explain:

10. Are you currently experiencing any thoughts of harm to others? Yes No If yes, please explain:

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11. Do you have a history of alcohol use? If so, how much? (now) ____/day; (and in the past) ____/day

12. Do you have a history of recreational drug use? If so, how much? (now) ____/day; (and in the past) ____/day

13. Are you currently exhibiting any of the following symptoms?

Fatigue	Yes	No	Unusual Fears	Yes	No	Nightmares/Bad Dreams	Yes	No
Anxiety	Yes	No	Change in Mood	Yes	No	Hearing Voices	Yes	No
Worries	Yes	No	Poor Concentration	Yes	No	Stomach Problems	Yes	No
Hyperactivity	Yes	No	Frequent Anger Outbursts	Yes	No	Poor Appetite	Yes	No
Stealing	Yes	No	“Sleep Walking”	Yes	No	Bowel Problems	Yes	No
Lying	Yes	No	Difficulty Sleeping	Yes	No	Sexual Acting Out	Yes	No

If you answered yes to any of the previous questions, please give more details in the space below:

14. Trauma History: Have you ever experienced any of the following events? If yes, please indicate your age at the time of the event, and any other details you wish to provide (use back of paper if needed). Please indicate N/A next to each item that does not apply to you in any way.

Childhood neglect		Being bullied	
Childhood physical abuse		Natural disaster	
Childhood sexual abuse		Death of a loved one	
Childhood loss of a parent		Witnessed another’s suicide or murder	
Rape/sexual assault		Experienced a suicide attempt	
Physical assault		Military combat	
Domestic violence		Have/or have had a life threatening illness	
Community violence		Transportation accident	

15. Do you have a history of an arrest/probation/incarceration? Yes No If yes, please explain: _____

16. Please list any additional concerns. _____
