JENNIE MURPHY
FAMILY THERAPY

# ADULT INTAKE PAPERWORK

***For couples therapy, both partners should each complete a separate copy of this document.***
***For family therapy, all adults involved should each complete a separate copy of this document.***

**Client Name** _____ **DOB** _____
**Partner's Name (if applicable)** _____ DOB _____

## Address:

Street Address: _____
City: _____ State:_____ Zip Code: _____
Mailing Address (if different than street address): _____
City: _____ State:_____ Zip Code: _____

## Contact Information:

Cell Phone: _____
Home Phone: _____
Other: (specify) _____
May I identify myself and leave a message at the phone numbers listed above? □ NO □ YES

May I contact you through email? □ NO □ YES
If yes, at the following email address:
_____

**Would you like to receive automated appointment reminders?**

☐ **NO** ☐ **YES, by text message to my cell**
☐ **YES, by email to my email address**

## How did you find Jennie Murphy Family Therapy, LLC?

□ Former client
□ Website
□ Psychology Today
□ Direct Referral, by: _____

## Relationship Status:

□ Married
□ Single
□ Widowed
□ Divorced
□ Separated
□ Living together
□ Engaged
□ Other: _____

## Ethnicity:

□ African-American/Black
□ Caucasian/White
□ Hispanic/Latino
□ Asian/Pacific Islander
□ Indian
□ Arabic
□ Jewish
□ Other: _____

## Employment Status:

□ Full-Time
□ Part-Time
□ Unemployed
□ Disabled
□ Not working, not looking for work
□ Student
□ Other: _____

## Emergency Contact:

Name of Emergency Contact: _____

Phone Number: _____ Relationship to you: _____

I give Jennie Murphy Family Therapy, LLC permission to contact the person listed above in the case of an emergency.

_____ _____
Client Signature Date

## PHYSICAL HEALTH HISTORY

Primary Doctor: _____ Telephone Number: _____

Check all that apply:
□ fibromyalgia □ cardiac event □ diabetes □ migraines
□ stroke □ thyroid disorder □ asthma □ traumatic brain injury
□ recent illness: _____
□ surgery: _____
□ allergies: _____
□ other: _____

**Medication Log:**

| Medication | Dosage | Frequency | Prescribed by: | Effective? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you take your medication regularly and as prescribed? □ NO □ YES

## MENTAL HEALTH HISTORY

Have you ever been to therapy before? □ NO □ YES
If YES, where? _____
If YES, when? _____
If YES, how was it helpful? _____

Are you currently under the care of a psychiatrist? □ NO □ YES
Psychiatrist: _____ Telephone Number: _____
Have you seen the psychiatrist in the last 6 months? □ NO □ YES

Do you have a history of ER visits or hospitalization for mental health treatment: □ NO □ YES
Total admissions: _____ Hospitalized in the last 2 years? □ NO □ YES

To your knowledge, have you ever been given a mental/behavioral health diagnosis? □ NO □ YES
If YES, what was the diagnosis? _____

Please indicate if you have a **family history** of any of the following?

| | **Circle** | **List Family Members (e.g., mom, grandpa, son, etc.)** |
|---|---|---|
| Alcohol/Drug Abuse | YES or NO | _____ |
| Anxiety | YES or NO | _____ |
| Depression | YES or NO | _____ |
| Domestic Violence | YES or NO | _____ |
| Eating Disorders | YES or NO | _____ |
| Obesity | YES or NO | _____ |
| Obsessive Compulsive Behavior | YES or NO | _____ |
| Schizophrenia | YES or NO | _____ |
| Suicide Attempts | YES or NO | _____ |

## LEGAL HISTORY

Are you experiencing any legal problems at this time? □ NO □ YES, explain:
_____
_____

Are you currently pursuing legal separation/divorce and/or child custody, or do you plan to in the future?
□ NO □ YES

Are you court ordered for treatment?
□ NO □ YES, agency & case worker/officer: _____

Are you or your family involved with a DSS case?
□ NO □ YES, case worker: _____

Are you currently applying for disability, or do you plan to apply in the future?
□ NO □ YES

## FAMILY COMPOSITION

Who do you currently live with?

| Name | Age or DOB | Relationship to you | If child, ours/his/hers? Adopted? Foster? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## CONCERNS FOR YOU AND YOUR FAMILY

| List the problem(s) you want help for in therapy. | | | | | |
|---|---|---|---|---|---|
| Problem | When it began | How distressed do you feel about this problem? | | | |
| | | **A little** | **Moderate** | **Quite a bit** | **Extreme** |
| | | 1 | 2 | 3 | 4 |
| | | 1 | 2 | 3 | 4 |
| | | 1 | 2 | 3 | 4 |

Please check all concerns you have for **YOURSELF:**

- ❑ depression
- ❑ anxiety/worries
- ❑ stress
- ❑ sexual abuse/rape
- ❑ eating disorder
- ❑ relationship problem
- ❑ family relationships
- ❑ parenting
- ❑ excessive alcohol/drugs
- ❑ chronic illness/pain/physical issue
- ❑ sexual problems
- ❑ panic attacks
- ❑ self-esteem
- ❑ lack of assertiveness
- ❑ avoidance of social situations
- ❑ stress due to traumatic event
- ❑ hearing or seeing things that others don't
- ❑ suicidal thoughts
- ❑ anger
- ❑ grief
- ❑ self-injury/self-mutilation
- ❑ sexual addiction
- ❑ ADD/ADHD symptoms
- ❑ problems with decision-making
- ❑ feeling "stuck"
- ❑ changes in eating habits
- ❑ changes in sleeping patterns
- ❑ changes in motivation or interest in doing things you'd normally enjoy
- ❑ other (please specify):

_____

**LIFE TRANSITIONS** you are experiencing currently (or have recently): ❑Not applicable

- ❑ first marriage
- ❑ parenting a new child
- ❑ new job
- ❑ lost job
- ❑ divorce
- ❑ separation
- ❑ remarriage
- ❑ remarriage with children
- ❑ moving
- ❑ creating a relationship/partnership
- ❑ dissolving a relationship/partnership
- ❑ change in religion/ belief system
- ❑ abortion
- ❑ miscarriage
- ❑ coming out as LGBT
- ❑ adjusting to illness/diagnosis
- ❑ adjusting to family caregiving needs
- ❑ other (please specify):

_____

Experiences you had **BEFORE AGE 18**: ❑Not applicable

- ❑ parental divorce
- ❑ emotional distance
- ❑ physical abuse
- ❑ emotional/verbal abuse
- ❑ financial problems
- ❑ homelessness
- ❑ unwanted touching
- ❑ sexual abuse
- ❑ alcohol/drug addiction
- ❑ other (please specify):

_____

- ❑ other (please specify):

_____

**SUBSTANCE USE:**

In general, how often do you drink alcohol?

- ❑ Never
- ❑ Less than once a month
- ❑ About once a week
- ❑ Several days per week
- ❑ Daily

Do you drink more now than you used to?

❑Yes ❑No

Has anyone objected to your drinking?

❑Yes ❑No

Are you using street drugs or have you?

❑Yes ❑No

Please check all concerns you have for your **SPOUSE/PARTNER**: ❑Not applicable

- ❑ depression
- ❑ anxiety/worries
- ❑ stress
- ❑ sexual abuse/rape
- ❑ eating disorder
- ❑ relationship problem
- ❑ family relationships
- ❑ parenting
- ❑ excessive alcohol/drugs
- ❑ chronic illness/pain/physical issue
- ❑ sexual problems
- ❑ panic attacks
- ❑ self-esteem
- ❑ lack of assertiveness
- ❑ avoidance of social situations
- ❑ stress due to traumatic event
- ❑ hearing or seeing things that others don't
- ❑ suicidal thoughts
- ❑ anger
- ❑ grief
- ❑ self-injury/self-mutilation
- ❑ sexual addiction
- ❑ ADD/ADHD symptoms
- ❑ problems with decision-making
- ❑ feeling "stuck"
- ❑ changes in eating habits
- ❑ changes in sleeping patterns
- ❑ changes in motivation or interest in doing things he/she'd normally enjoy
- ❑ other (please specify):

_____

Please check all concerns you have for your **MARRIAGE/RELATIONSHIP**: ❑Not applicable

- ❑ poor communication
- ❑ arguing about finances
- ❑ not enough time together
- ❑ too much time together
- ❑ fighting/arguing
- ❑ punching/slapping/hitting
- ❑ infidelity/affairs
- ❑ managing past relationships
- ❑ excessive alcohol/drugs
- ❑ refuses sex too often
- ❑ demands sex too often
- ❑ physical sexual problems (impotence, painful intercourse, etc.)
- ❑ pornography use
- ❑ parenting differences
- ❑ partner too controlling
- ❑ different values
- ❑ emotional abuse
- ❑ difficulties with in-laws/extended family
- ❑ other (please specify):

_____

Please check all concerns you have for your **CHILDREN/FAMILY**: ❑Not applicable

- ❑ behavior problems
- ❑ drugs/alcohol
- ❑ adolescent pregnancy
- ❑ ADD/ADHD symptoms
- ❑ sexual abuse
- ❑ anxiety
- ❑ depression
- ❑ divorce adjustment
- ❑ death in family
- ❑ anger
- ❑ peer relationships
- ❑ poor self-esteem
- ❑ bed-wetting/soiling
- ❑ destructiveness
- ❑ issues with step-children/step-parenting
- ❑ eating disorder
- ❑ self-injury/self-mutilation
- ❑ other (please specify):

_____

## ADDITIONAL INFORMATION

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

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

Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
If yes, describe your faith or belief: _____
_____

What qualities, characteristics, or areas in your life are your *greatest strengths*?
_____
_____

What qualities, characteristics, or areas in your life *need improvement*?
_____
_____

## EXPECTATIONS FOR THERAPY

Would you be interested in allowing other family members to participate in therapy by joining one or more session(s)? Please explain your expectations for family involvement in therapy:
_____
_____

Please rate the following five statements from 1 to 5 in the order that best describe your hope for therapy. (1 is your greatest hope for therapy and 5 is your least):

_____ I have a very specific problem, and I am willing to do whatever it takes to resolve it.
_____ I am looking for some helpful advice, tips, and/or tools to address my current problem.
_____ I want to get someone off my back (e.g. Mom, court, DSS).
_____ I need extra support in my life and a listening ear to help me process my current situation.
_____ I want to understand how my past experiences have made me who I am.

Many clients report "feeling better" after just one or two therapy sessions, but the number of sessions needed to reach treatment goals cannot be precisely predicted. Understanding that therapy is a commitment and you may not be able to reach your goals in the time frame you choose, please check you the time frame you expect to achieve your goals in therapy:

❑ 6 sessions or less
❑ 10 sessions or less
❑ 20 sessions or less
❑ As long as it takes, up to a year or two

Additional comments? Is there anything else you want me to know about you?
_____
_____