David T. Wood, MA, LMFT
Marriage & Family Therapist

INTAKE FORM

Personal Data (Yourself):

Name_____ Age_____ Gender____ DOB___/___/___
Phone # (to contact)_____ Spouse #_____Alternate #_____
Street Address_____ City_____ZIP_____
Mail Address_____ Occupation & Employer_____
MaritalStatus_____ School Years Completed_____ Family Gross Annual Income $ _____

Spouse/Partner Data (if applicable):

Name_____ Age_____ DOB___/___/___ School Yrs. Completed____
Anniversary Date___/___/___ Occupation_____Home Church_____

Family Data (others living with you):

Name	*Age*	*Gender*	*Relationship (to yourself)*

Previous counseling experience (reasons & dates)_____
_____
_____

Medical Information: ***Date & reasons for last physical exam for self and spouse/partner (if applicable)***

Self:_____
Spouse:_____

Current medications (prescription, over-the-counter, herbal supplements)

Self:_____
Spouse:_____

Allergies

Self:_____
Spouse:_____

History of serious accident or illness

Self:_____
Spouse:_____

CURRENT CONCERNS

Describe the reasons you are seeking counseling:

_____
_____
_____

Emergency contact person_____ phone_____
Primary Care Physician_____ phone_____
Referred by_____

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Substance Use & History

	Self				Spouse/other		
tobacco (any form)	__Current	__Past	__None	tobacco (any form)	__Current	__Past	__None
alcohol	__Current	__Past	__None	alcohol	__Current	__Past	__None
caffeine (any form)	__Current	__Past	__None	caffeine (any form)	__Current	__Past	__None
recreational drugs	__Current	__Past	__None	recreational drugs	__Current	__Past	__None
type(s)_____				type(s)_____			

From the lists below, please indicate your concerns.
Male clients use "X"
Female clients use "O"
For each client rank your top 5 concerns by number behind the term.
(#1 = most important, etc.)

STRESSORS

Additional Comments:

___aggression
___anger
___anxiety
___authority
___career
___communication
___compulsions
___concentration
___depression
___faith
___fears
___finances
___grief/loss
___guilt
___helplessness
___impulsiveness
___indecision
___in-laws
___irritability
___legal matters
___loneliness
___marriage
___nervousness
___parenting
___physical abuse
___problem-solving
___relaxation
___self-harm/suicide
___sexual abuse
___sexual intimacy
___shyness
___sleeplessness
___verbal abuse
___work
___worry
___other

PHYSICAL SYMPTOMS

Additional Comments:

___pain (in) _____
___nausea
___balance
___nerve
___digestion
___weight change
___vision
___hearing
___fatigue
___numbness
___heart
___other

What are the personal/family strengths, skills and abilities which have helped you to cope so far?

_____

_____

Have you any goals or expectations as to how counseling may help you?

_____

_____