FAMILY & CHILD DEVELOPMENT

348 Miracle Strip Parkway, Suite B-3
Ft. Walton Beach, FL 32563
www.familyandchilddevelopment.com
Phone: (850) 862-3772
FAX: (850) 863-4574

Don G. Brown, M.Ed., Th.D., LMFT
E. Glyn Brown, Ph.D., LMFT
Pearle K. Brown, Ed.D. LMFT
Beverlee K. Mueller, M.S., LMFT, LMHC
Claudia A. Hamilton, M.A., LMFT
Taylor Ferguson, M.A., Registered Intern
Julia Humbarger, M.S., Registered Intern

Individual Intake Form

Thank you for taking the time to complete this intake form. Please note that the information you provide here is protected as confidential information. Please complete all items if possible. If you have any questions, please ask.

I. IDENTIFICATION

Your Name: _____ Birthdate: _____

Spouse/Partner: _____ Birthdate: _____

Marital status (please circle one):

Married ☐ Never Married ☐ Separated ☐ Divorced ☐

List child(ren) and ages: _____

_____

Home address: _____

Street City State Zip Code

Home phone number: _____ May we leave a message? _____ Yes _____ No

Cell: _____ May we leave a message? _____ Yes _____ No

Email address: _____ May we email you? _____ Yes _____ No

Occupation: _____ Employer: _____

Referred by (if applicable):_____

II. PRESENTING PROBLEM(S)

Please give a description of the presenting problem or major complaint that brings you in here today:
_____
_____
_____
_____
_____

Please give a brief description of the history of the problem and how you have tried to handle it._____
_____
_____
_____
_____

What specifically do you expect your counselor to do to help you with your concern? _____
_____
_____

III. YOUR MENTAL HEALTH HISTORY

Have you previously received any mental health or substance abuse services? _____ Yes _____ NO

Date	Facility	Inpatient/Outpatient	Diagnosis

What do you consider to be the top three stressors in your life?

1. _____
2. _____
3. _____

Psychological Symptoms

Emotions: Select any of the following that you find troubling and/or applied to you in the last month.		
_____Anxious	**_____ Easily excitable**	**_____ Lonely**
_____ Angry	**_____ Fearful**	**_____ Relaxed**
_____ Bored	**_____ Frustrated**	**_____ Restless**
_____ Confused	**_____ Guilty**	**_____ Sad**
_____ Contented	**_____ Happy**	**_____ Suspicious**
_____ Distrustful	**_____ Hopeless**	**_____ Tense**
_____ Energetic	**_____ Jealous**	**_____ Other: _____**

Behaviors: Select any of the following that you find troubling and/or applied to you in the last month.

_____ Aggression	**_____ Hurting self**	**_____ Oversleeping**
_____ Attention problems	**_____ Hurting others**	**_____ Risk taking**
_____ Avoiding activities	**_____ Impulsiveness**	**_____ Spending sprees**
_____ Avoiding/people/places	**_____ Increased drinking**	**_____ Taking mood altering drugs**
_____ Concentration problems	**_____ Increased energy**	**_____ Temper outbursts**
_____ Crying	**_____ Increased smoking**	**_____ Under eating**
_____ Decreased energy	**_____ Isolation**	**_____ Vomiting**
_____ Decreased interests	**_____ Loss of control**	**_____ Under sleeping**
_____ Employment difficulty	**_____ Nightmares**	**_____ Fearful**
_____ Flashbacks	**_____ Overeating**	**_____ Other: _____**

Do you drink alcohol? _____ YES _____ NO If yes, how much each time? _____

How often do you engage in recreational drug use? (circle one please)

Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Never ☐

Are you experiencing overwhelming grief or depression? _____ YES _____ NO; for how long? _____

Are you experiencing anxiety, panic attacks or phobias? _____ YES _____ NO; for how long? _____

Do you feel you would be better off dead? _____ YES _____ NO

Have you ever attempted suicide? _____ YES _____ NO; If yes, what were the circumstances? _____

_____

IV. FAMILY MENTAL HEALTH HISTORY

Is there a family history of any of the following? Please indicate which family members may have experienced any of the following.

Alcoholism (who and for how long?): _____

_____

_____

Substance abuse (who and for how long?): _____

_____

_____

Mental Illness (who and what diagnosis?): _____

_____

_____

Serious Illness or Hospitalizations (who and for how long): _____

_____

_____

Is there any history of physical, emotional, verbal, or sexual abuse? _____ Yes _____ No
Please list victims, including yourself. _____
_____
_____

V. MEDICAL HISTORY

Your medical information is used to detect possible medical conditions that may require a physician's attention. This may result in a recommendation that you consult with your physician for further examination.

Your Physician's Name: _____ Phone: _____

Current medications and dosage: _____
_____
Past medications: _____
_____
_____

Symptom Checklist

Please check the symptoms or conditions that have applied to you at any time.

_____Alcoholism	**_____ Epilepsy**	**_____ Kidney disease**
_____ Allergies	**_____ Head trauma**	**_____ Liver disease**
_____ Anemia	**_____ Hearing problems**	**_____ Seizures**
_____ Cancer/tumors	**_____ Heart disease**	**_____ Smoking**
_____ Diabetes	**_____ Hepatitis**	**_____ Stroke**
_____ Eating problems	**_____ High blood pressure**	

Please check the symptoms or conditions that frequently apply to you.

_____ Abdominal pain	**_____ Fainting**	**_____ Sexual problems**
_____ Attention problems	**_____ Hurting others**	**_____ Risk taking**
_____ Avoiding activities	**_____ Impulsiveness**	**_____ Spending sprees**
_____ Avoiding/people/places	**_____ Increased drinking**	**_____ Taking mood altering drugs**
_____ Concentration problems	**_____ Increased energy**	**_____ Temper outbursts**
_____ Crying	**_____ Increased smoking**	**_____ Under eating**
_____ Decreased energy	**_____ Isolation**	**_____ Vomiting**
_____ Decreased interests	**_____ Loss of control**	**_____ Under sleeping**
_____ Employment difficulty	**_____ Nightmares**	**_____ Fearful**
_____ Flashbacks	**_____ Overeating**	**_____ Other: _____**

VI. ABOUT YOUR EDUCATION

What is the highest level of education you have completed? _____

While in school, did you have a learning disability that required additional services? If so, please describe._____

_____

While in school, did you have behavioral problems? If so, please describe. _____

_____

VII. RELATIONSHIP INFORMATION (if applicable)

If you are married, is this your first marriage? _____ YES _____ NO; If not, how many times have you been married? _____

Is this your spouse's first marriage? _____ YES _____ NO

Are there step-children involved? _____ YES _____ NO

On a scale of 1 – 10, how would you rate your relationship? _____

What difficulties are you facing in your relationship? _____

_____

Have either you or your partner threatened to separate or divorce as a result of the current problems?

_____ YES _____ NO; if yes, please explain who and what problem(s). _____

_____

How frequently have you had sexual relations during the last month? _____

On a scale of 1 – 10, how enjoyable is your sexual relationship? _____

On a scale of 1 – 10, how satisfied are you with the frequency of your sexual relations? _____

On a scale of 1 – 10, to what degree do your family or friends support you as a couple? _____

On a scale of 1 – 10, to what degree do you and your partner share a similar worldview? _____

VIII. ADDITIONAL INFORMATION

What is your current job description? _____

_____

On a scale from 1 – 10, how well do you enjoy your job and why? _____

_____

Do you have legal problems? If so, please explain. _____

_____

Are you court ordered to come into treatment? _____ YES _____ NO. If so, who is the referral source and what are the requirements and circumstances surrounding it? _____

_____

_____

What is your religious/spiritual background? _____

_____

Please describe at least five (5) significant strengths that you hold about yourself. _____

_____
_____

Please describe what you consider some of your weaknesses. _____

_____
_____

What are your goals/objectives for treatment?

Goal 1: _____
_____

Goal 2: _____
_____

Goal 3: _____
_____