The Office of Amanda Medina, MA
Licensed Marriage & Family Therapist

# Couple or Family Intake Questionnaire

1) (Last) ______________________ (First) ____________________ DOB: _________ Age: ____
2) (Last) ______________________ (First) ____________________ DOB: _________ Age: ____
3) (Last) ______________________ (First) ____________________ DOB: _________ Age: ____
4) (Last) ______________________ (First) ____________________ DOB: _________ Age: ____

Other Household Members: ____________________________________________________________

(Indicate who by circling number)

Full Address:__________________________________________________________________ 1 2 3 4
Full Address:__________________________________________________________________ 1 2 3 4

(*indicate preferred; may I contact you at these numbers?)

Phone Number: _____________________(cell); __________________(circle one: wk/hm/other ) 1234
Phone Number: _____________________(cell); __________________(circle one: wk/hm/other ) 1234
Occupation:__________________________1 2 3 4; Occupation_______________________1 2 3 4
School/Grade:______________________1 2 3 4; School/Grade______________________ 1 2 3 4
Ethnicity ______________1234______________1234______________1234______________1234
Annual household income _______________ Do you own or rent? __________
__never married ___married ___divorced __widowed ___coupled ___separated How Long?_____
If married or coupled, how would you describe the quality of your relationship: ______________________
_____________________________________________________________________________________
What issues/concerns cause you to seek treatment? Please describe. _____________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Do you have any specific goals with regard to your treatment? __________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

8331 Sierra College Boulevard, Suite 222 ~ Roseville, CA 95661
T 916.474.0248 ~ F 916.746.8634

Indicate who (1 2 3 4) has any of the following symptoms:

____Thoughts of Suicide ____ Work Problems ___ Depression ___Anxiety
____ Relational Problems ____Anorexia/Bulimia ___Harm yourself ___ Trauma
____ Problems with intimacy ____School Problems ___ Legal Problems ___ Violence
____ Difficulty with Anger ____ Drugs/Alcohol ____ Sexual/Physical/Emotional abuse
___Other_______________________________________________________________

(Indicate which family member)

Medical Illness: ________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Current Medications: ________________________________________________________________
________________________________________________________________

Prescribing Doctor(s)/Phone: ________________________________________________________________

Has anyone ever taken medication for mental health symptoms? ______________________________
________________________________________________________________

Other Health Concerns: ________________________________________________________________
________________________________________________________________

Prior mental health treatment:

Name of Therapist Dates (from when to when) Reason

________________________________________________________________1234
________________________________________________________________1234
________________________________________________________________1234

Have any treatment members participated in psychological tests? ______________________________

If so, name of person(s) that administered psychological tests ______________________________

Have any treatment members been hospitalized for mental or emotional problems? Describe circumstances:
________________________________________________________________
________________________________________________________________

Have any treatment members ever attempted suicide? When?___________________________________
Describe the circumstances that led to that attempt __________________________________________
_____________________________________________________________________________________
Is there a family history of mental, emotional, or substance abuse problems? _____________________
_____________________________________________________________________________________
Relationship with Extended Family: ______________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Additional supportive people in your life: _________________________________________________
Please describe the role of religion or spirituality in your family. ______________________________
_____________________________________________________________________________________
Do you attend church? If so, where/how often? ___________________________________________
Describe Family Strengths ______________________________________________________________
_____________________________________________________________________________________
Family Interests/Hobbies _______________________________________________________________
_____________________________________________________________________________________
Individual Family Member Strengths:
1:____________________________________________________________________________________
2: ___________________________________________________________________________________
3: ___________________________________________________________________________________
4: ___________________________________________________________________________________

* Please feel free to attach additional pages with any information you feel would be helpful for treatment.

Signature of person filling out form: ___________________________________ Date _____________