Donna Gugliotta, M.S., LMFT

Marriage and Family Therapist

INITIAL INTAKE FORM

Name: _____

Social Security #: _____ Occupation/Employer: _____

Address: _____

Home phone: _____ cell: _____ work: _____

Preferred means of contact: Home phone, cell or work phone. Circle best one.

Name of Spouse/Partner/Guardian: _____ Phone: _____

Children? Names and ages: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who referred you to me? _____

DEMOGRAPHIC INFORMATION

Gender: Male Female Date of Birth: _____ Age: _____

Ethnicity: Circle one. African American, Asian-American/Pacific Islander, Caucasian/White, Hispanic, Native American/Indian, Multi-racial, Other; _____

Highest Education Completed: High School, Bachelors, Masters, Ph. D, M.D., N/A, Religion _____

Marital Status: Circle one. Single, Married, Separated, Divorced, Widowed, Domestic Partner

PRESENTING PROBLEM

What do you want to see me about?

_____

_____

How long has this been a problem? _____

What would you like to be different? _____

PREVIOUS TREATMENT

Have you received mental health services before? No or Yes, with:

Name and Dates: _____ Name/Dates: _____

Name/Dates:_____Name/Dates:_____

Have you ever been psychiatrically hospitalized? Circle one. No or Yes, If yes, when and where?

Have you ever taken prescription ***psychiatric medication***? Previously or Currently. Circle one.

What were/are you taking (names and dosages)? _____

What is the name, address and phone number of your prescribing psychiatrist or doctor who is prescribing the psychiatric medication? _____

_____

How long have you been taking the psychiatric medication?_____

MEDICAL HISTORY

Do you have (or have you ever had) any significant medical problems? No or Yes. If yes, please describe:

Are you taking any medications for medical conditions? No or Yes, If yes, please list:_____

Do you have any family history of serious medical or psychological problems? No or Yes, If yes, please list:_____

ALCOHOL AND SUBSTANCE USE

Do you drink alcohol? Yes or No How many drinks do you consume per day? _____ Per week _____

Do you use drugs? Yes or No Drug Names? _____How many times per week do you use?_____

Do you believe that alcohol or drugs are adversely impacting your work, relationships, or mood? Yes or No

OTHER PROBLEM AREAS

Please circle any of the following areas for which you would like help:

Anger	Stress	Obsessions	Self-Esteem	Relationships	Parenting
Assertiveness	Depression	Compulsions	Career	Sex	Academic
Alcohol Abuse	Anxiety	Insomnia	Low Energy	Mood Swings	Identity Issues
Substance Abuse	Panic	Loneliness	Procrastination	Mania	Trauma