

Therapist ID:

Session #:

Date:

Client #:

Name:

## AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CLINIC

### *Individual Adult Intake*

**The first section will focus on individual depression and anxiety over the last 2 weeks. Information is confidential.**

	<i>All the Time</i>	<i>Most Times</i>	<i>More than Half the Time</i>	<i>Less than Half the Time</i>	<i>Some-times</i>	<i>At No Time</i>
1. Have you felt low in spirits or sad? .....	5	4	3	2	1	0
2. Have you lost interest in your daily activities? .....	5	4	3	2	1	0
3. Have you felt lacking in energy and strength? .....	5	4	3	2	1	0
4. Have you felt less self- confident? .....	5	4	3	2	1	0
5. Have you had a bad conscience or feelings of guilt? .....	5	4	3	2	1	0
6. Have you felt that life wasn't worth living? .....	5	4	3	2	1	0
7. Have you had difficulty in concentrating, e.g. when reading the newspaper or watching TV? .....	5	4	3	2	1	0
8. (A) Have you felt very restless? .....	5	4	3	2	1	0
(B) Have you felt subdued or slowed down? .....	5	4	3	2	1	0
9. Have you had trouble sleeping at night? .....	5	4	3	2	1	0
10. (A) Have you suffered from reduced appetite? .....	5	4	3	2	1	0
(B) Have you suffered from increased appetite? .....	5	4	3	2	1	0

	<i>Not at All</i>	<i>Several Days</i>	<i>More than Half the Days</i>	<i>Nearly Every Day</i>
1. Feeling nervous, anxious or on edge .....	0	1	2	3
2. Not being able to stop or control worrying .....	0	1	2	3
3. Worrying too much about different things .....	0	1	2	3
4. Trouble relaxing .....	0	1	2	3
5. Being so restless that it is hard to sit still .....	0	1	2	3
6. Becoming easily annoyed or irritable .....	0	1	2	3
7. Feeling afraid as if something awful might happen .....	0	1	2	3

	<i>Not Difficult</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
8. How difficult have these problems made it for you to do your work, take care of the home, or get along with others? .....	0	1	2	3

**The next section will focus on change.**

Please indicate the extent to which you tend to agree or disagree with each statement as a description of you right now.

	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1. I am doing something about the problems that have been bothering me .....	1	2	3	4	5
2. I am really working hard to change .....	1	2	3	4	5
3. I wish I had more ideas on how to solve the problem .....	1	2	3	4	5
4. I have started working on my problems but I would like help .....	1	2	3	4	5
5. Maybe this place will be able to help me .....	1	2	3	4	5
6. I may be part of the problems, but I don't really think I am .....	1	2	3	4	5
7. I hope that someone here will have some good advice for me .....	1	2	3	4	5
8. Anyone can talk about changing; I'm actually doing something about it .....	1	2	3	4	5
9. All this talk about psychology is boring. Why can't people just forget about their problems? .....	1	2	3	4	5
10. I have worries but so does the next guy. Why spend time thinking about them? .....	1	2	3	4	5
11. I am actively working on my problem .....	1	2	3	4	5
12. I would rather cope with my faults than try to change them .....	1	2	3	4	5

**The next section will focus on the stress, sexuality, health, sleep.**

The questions in this scale ask you about your **feelings and thoughts** during the last month.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
1. How often have you been upset because of something that happened unexpectedly?.....	0	1	2	3	4
2. How often have you felt that you were unable to control the important things in your life?.....	0	1	2	3	4
3. How often have you felt nervous and "stressed"?.....	0	1	2	3	4
4. How often have you felt confident about your ability to handle your personal problems?.....	0	1	2	3	4
5. How often have you felt that things were going your way?.....	0	1	2	3	4
6. How often have you found that you could not cope with all the things that you had to do? .....	0	1	2	3	4
7. How often have you been able to control irritations in your life?.....	0	1	2	3	4
8. How often have you felt that you were on top of things?.....	0	1	2	3	4
9. How often have you been angered because of things that were outside of your control?.....	0	1	2	3	4
10. How often have you felt difficulties were piling up so high that you could not overcome them?.....	0	1	2	3	4

How often have you experienced the following symptoms over the last two months? Never-----Often

1. Sexual problems.....	0	1	2	3
2. Low sex drive .....	0	1	2	3
3. Sexual over-activity .....	0	1	2	3
4. Not feeling satisfied with your sex life.....	0	1	2	3
5. Having sex that you didn't enjoy.....	0	1	2	3
6. Bad thoughts or feelings during sex .....	0	1	2	3
7. Being Confused about your sexual feelings .....	0	1	2	3
8. Sexual feelings when you shouldn't have them .....	0	1	2	3

Would you be willing to report your: **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

1. Circle the best answer. In general, would you say your health is *Excellent* *Very Good* *Good* *Fair* *Poor*

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? Circle the best answer.

- a. Moderate activities, (e.g. moving a table, vacuuming, or golf) *Yes, limited a lot* *Yes, limited a little* *No, not at all*
- b. Climbing several flights of stairs *Yes, limited a lot* *Yes, limited a little* *No, not at all*

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health (such as feeling depressed or anxious)?

- a. Accomplished less than you would like *Yes* *No*
- b. Were limited in the kind of work or other activities *Yes* *No*

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- a. Accomplished less than you would like *Yes* *No*
- b. Did work or other activities less carefully than usual *Yes* *No*

5. During the past 4 weeks, how much did pain interfere with your normal work (including both housework and work outside the home)? Circle the best answer.

*Not at All* *A Little Bit* *Moderately* *Quite a Bit* *Extremely*

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	<i>All of the Time</i>	<i>Most of the Time</i>	<i>A Good Bit of the Time</i>	<i>Some of the Time</i>	<i>A Little of the Time</i>	<i>None of the Time</i>
a. Have you felt calm and peaceful?.....	1	2	3	4	5	6
b. Did you have a lot of energy? .....	1	2	3	4	5	6
c. Have you felt downhearted and blue?.....	1	2	3	4	5	6

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? Circle the best answer.

*All of the Time      Most of the Time      Some of the Time      A Little of the Time      None of the Time*

8. During the last month how many times have **you** visited medical providers such as primary care or family doctors, internists, surgeons or medical specialists, physicians assistants or medical nurse practitioners as an outpatient? \_\_\_\_\_

9. During the last month how many nights have **you** stayed in a hospital? \_\_\_\_\_

10. Do **you** have health insurance? Circle the best answer.      NO      YES

11. Do **you** have a chronic illness? Circle the best answer.      NO      YES If yes, please specify: \_\_\_\_\_

**How often during the past 4 weeks did you...**

	<i>All of the Time</i>	<i>Most of the Time</i>	<i>Some of the Time</i>	<i>A Little of the Time</i>	<i>None of the Time</i>
1. Get enough sleep to feel rested upon waking in the morning?.....	1	2	3	4	5
2. Awaken short breath or with a headache? .....	1	2	3	4	5
3. Have trouble falling asleep? .....	1	2	3	4	5
4. Awaken during your sleep time and have trouble falling asleep? .....	1	2	3	4	5
5. Have trouble staying awake during the day? .....	1	2	3	4	5
6. Get the amount of sleep you needed? .....	1	2	3	4	5

**This section will focus on demographics.**

1. Your age: \_\_\_\_\_ 2. Your Sex: \_\_\_\_\_ 3. Partner Sex: \_\_\_\_\_

4. Racial/Ethnic Group (Specify): \_\_\_\_\_

5. How many times have you been married? \_\_\_\_\_ 6. How many times has your partner been married? \_\_\_\_\_

7. Your current relationship/marital status is: Circle the best answer.

*A. Single/Never Married    B. Married    C. Divorced    D. Separated*  
*E. Widowed    F. Committed Relationship (Not Living Together)    G. Committed Relationship (Living Together)*

8. Your current relationship length (years & months)? \_\_\_\_\_

9. How many biological, adopted, step-children under 18 live in your home at least 50% of the time? \_\_\_\_\_

10. How many total people live in your home? \_\_\_\_\_

11. What is the highest level of education you attained? Circle the best answer.

*A. Junior High School or less    B. GED/High School    C. Vocational/Technical School*  
*D. Associate Degree/2 years    E. Bachelor Degree    F. Graduate/Professional Degree*

12. What is your combined gross income (before taxes) in the current year Circle the best answer

*A. Under \$5,500    B. \$5,501 to \$11,999    C. \$12,000 to \$15,999*  
*D. \$16,000 to \$19,999    E. \$20,000 to \$24,999    F. \$25,000 to \$29,999*  
*G. \$30,000 to \$34,999    H. \$35,000 to \$39,999    I. \$40,000 to \$49,999*  
*J. \$50,000 to \$59,999    K. \$60,000 to \$69,999    L. \$70,000 to \$79,999*  
*M. \$80,000 to \$89,999    N. \$90,000 to \$99,999    O. \$100,000 or more*

13. Do you consider yourself to be: Circle the best answer.

*E. Not Religious/Spiritual    B. Slightly Religious/Spiritual    C. Moderately Religious/Spiritual*  
*D. Very Religious/Spiritual    E. Strongly Religious/Spiritual*

14. What spiritual/religious activities do you and your partner do on a regular basis **together**? Circle all that apply.
- A. Walk/Exercise                      B. Pray or Fast                      C. Attend worship services  
D. Meditate                      E. Read Religious Books/Scriptures                      F. Observe Religious Holidays  
G. Pray for Partner/Spouse                      H. Attend Spiritual/Religious Retreats                      I. Volunteer Religion/Community

15. What is your current religious/spiritual preference? \_\_\_\_\_

16. List any current physical health problems \_\_\_\_\_

17. List Prescription, herbal, or over-the-counter medications \_\_\_\_\_

18. If you have any current or previous experiences with counseling or therapy, provide the following information.

Name of counselor or agency	Reason for counseling	# of sessions	How helpful was counseling?		
			Not at all	Somewhat helpful	Very helpful
_____	_____	_____	1	2	3
_____	_____	_____	1	2	3

19. Please answer the following questions for the **family in which you grew up**. SEVERITY = The IMPACT on YOU.

In your <u>childhood family</u> , were there problems with:	Frequency			Severity		
	Once	Some	Often	Mild	Moderate	Severe
1. <b>Emotional Abuse:</b> Swearing, insults, threats..... N/A	1	2	3	1	2	3
2. <b>Physical Abuse:</b> Slapping, hitting, throwing things ..... N/A	1	2	3	1	2	3
3. <b>Sexual Abuse:</b> Being touched or touching someone sexually, forced sex ..... N/A	1	2	3	1	2	3
4. <b>Emotional Neglect:</b> Unloved, ignored, rejected ..... N/A	1	2	3	1	2	3
5. <b>Physical Neglect:</b> Not properly clothed, not fed, not taken to doctor (not because you were too poor) ..... N/A	1	2	3	1	2	3
6. <b>Mother Was Treated Violently:</b> She was pushed, bit, slapped, kicked, punched, threatened with knife/gun ..... N/A	1	2	3	1	2	3
7. <b>Substance Use and Abuse:</b> Alcohol abuse, drug use, or prescription abuse..... N/A	1	2	3	1	2	3
8. <b>Household Mental Illness:</b> Depression, mental illness ..... N/A	1	2	3	1	2	3
9. <b>Attempted Suicide or Suicide</b> ..... N/A	1	2	3	1	2	3
10. <b>Incarcerated Household Member</b> ..... N/A	1	2	3	1	2	3
11. <b>Parental Separation or Divorce</b> ..... N/A	1	2	3	1	2	3

20. How much did someone else pressure you to come for therapy? Circle the best answer.

Not at All                      A Little Pressure                      Somewhat Pressured                      Quite Pressured                      Very Pressured

21. Starting with the most important, please list the problems that brought you to therapy?

A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_

22. Do you consider the problems that brought you to therapy to be the responsibility of:

E. Yourself                      B. Your Spouse/Partner                      C. One of your Children  
F. You and your Spouse/Partner                      E. The Whole Family

23. Who referred you to the MFT clinic? Circle the best answer.

A. Friend                      B. Spouse/Partner                      C. Teacher                      D. Minister/Clergy                      E. Physician                      F. Former/Current Client  
G. Self-Referral                      H. Advertising (specify) \_\_\_\_\_                      Other: \_\_\_\_\_

24. Have you hired a lawyer or are you in litigation? Circle the best answer.                      YES                      NO

25. Are you currently in counseling with one or more other therapists? Circle the best answer.                      YES                      NO