Name: Session:
Therapist ID: Client #:

AUBURN MFT CLINIC: *Family Adult Intake*

This section will focus on your individual symptoms related to depression and anxiety over the last 2 weeks.

	Not at All	*Several Days*	*More than Half the Days*	*Nearly Every Day*
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed; Or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

	Not Difficult	*Somewhat*	*Very*	*Extremely*
10. 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

	Not at All	*Several Days*	*More than Half the Days*	*Nearly Every Day*
11. Feeling nervous, anxious or on edge	0	1	2	3
12. Not being able to stop or control worrying	0	1	2	3
13. Worrying too much about different things	0	1	2	3
14. Trouble relaxing	0	1	2	3
15. Being so restless that it is hard to sit still	0	1	2	3
16. Becoming easily annoyed or irritable	0	1	2	3
17. Feeling afraid as if something awful might happen	0	1	2	3

	Not Difficult	*Somewhat*	*Very*	*Extremely*
18. 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

0	*1*	*2*	*3*	*4*	*5*	*6*	*7*
Never	*Once*	*Twice*	*3-5 Times*	*6-10 Times*	*11-20 Times*	*More than 20 Times*	*Happened but Not in Past Year*

Using the following key, how often did **YOU** do the following during the past year?

1. Threw something (but not at a family member) or smashed something	0	1	2	3	4	5	6	7
2. Threatened to hit or throw something at a family member	0	1	2	3	4	5	6	7
3. Threw something at family member	0	1	2	3	4	5	6	7
4. Pushed, grabbed, or shoved a family member	0	1	2	3	4	5	6	7
5. Hit (or tried to hit) a family member but *not* with anything hard	0	1	2	3	4	5	6	7
6. Hit (or tried to hit) a family member with something hard	0	1	2	3	4	5	6	7

Using the same key as above, how often did **YOUR CHILD** do the following during the past year?

1.	Threw something (but not at a family member) or smashed something 0	1	2	3	4	5	6	7
2.	Threatened to hit or throw something at a family member 0	1	2	3	4	5	6	7
3.	Threw something at family member 0	1	2	3	4	5	6	7
4.	Pushed, grabbed, or shoved a family member 0	1	2	3	4	5	6	7
5.	Hit (or tried to hit) a family member but *not* with anything hard 0	1	2	3	4	5	6	7
6.	Hit (or tried to hit) a family member with something hard 0	1	2	3	4	5	6	7

The next section will focus on behavior of the child with the presenting problem in therapy.

Please rate the degree to which your child has experienced the following problems in the past 30 days.

		Not at All	*Once or Twice*	*Several Times*	*Often*	*Most of the Time*	*All of the Time*
1.	Arguing with others 0	1	2	3	4	5	
2.	Getting into fights 0	1	2	3	4	5	
3.	Yelling, swearing, or screaming at others 0	1	2	3	4	5	
4.	Fits of anger 0	1	2	3	4	5	
5.	Refusing to do things teachers or parents ask 0	1	2	3	4	5	
6.	Causing trouble for no reason 0	1	2	3	4	5	
7.	Using drugs or alcohol 0	1	2	3	4	5	
8.	Breaking rules or breaking the law (out past curfew, stealing) 0	1	2	3	4	5	
9.	Skipping school or classes 0	1	2	3	4	5	
10.	Lying 0	1	2	3	4	5	
11.	Can't seem to sit still, having too much energy 0	1	2	3	4	5	
12.	Hurting self (cutting or scratching self, taking pills) 0	1	2	3	4	5	
13.	Talking or thinking about death 0	1	2	3	4	5	
14.	Feeling worthless or useless 0	1	2	3	4	5	
15.	Feeling lonely and having no friends 0	1	2	3	4	5	
16.	Feeling anxious or fearful 0	1	2	3	4	5	
17.	Worrying that something bad is going to happen 0	1	2	3	4	5	
18.	Feeling sad or depressed 0	1	2	3	4	5	
19.	Nightmares 0	1	2	3	4	5	
20.	Eating problems 0	1	2	3	4	5	

Please rate the degree to which your child's problems affect his/her current ability in activities. Consider your child's functioning.

		Extreme Troubles	*Quite a Few Troubles*	*Some Troubles*	*OK*	*Doing Very Well*
1.	Getting along with friends 0	1	2	3	4	
2.	Getting along with family 0	1	2	3	4	
3.	Dating or developing relationships with boyfriends or girlfriends 0	1	2	3	4	
4.	Getting along with adults outside the family (teachers, principal) 0	1	2	3	4	
5.	Keeping neat and clean, looking good 0	1	2	3	4	
6.	Caring for health needs and keeping good health habits (taking medicines or brushing teeth) 0	1	2	3	4	
7.	Controlling emotions and staying out of trouble 0	1	2	3	4	
8.	Being motivated and finishing projects 0	1	2	3	4	
9.	Participating in hobbies (baseball cards, coins, stamps, art) 0	1	2	3	4	
10.	Participating in recreational activities (sports, swimming, bike riding) 0	1	2	3	4	
11.	Completing household chores (cleaning room, other chores) 0	1	2	3	4	
12.	Attending school and getting passing grades in school 0	1	2	3	4	
13.	Learning skills that will be useful for future jobs 0	1	2	3	4	
14.	Feeling good about self 0	1	2	3	4	
15.	Thinking clearly and making good decisions 0	1	2	3	4	

16. Concentrating, paying attention, and completing tasks 0	1	2	3	4
17. Earning money and learning how to use money wisely 0	1	2	3	4
18. Doing things without supervision or restrictions 0	1	2	3	4
19. Accepting responsibility for actions 0	1	2	3	4
20. Ability to express feelings 0	1	2	3	4

The next section will focus on health and sleep.

Would you be willing to report your: **Height**: _____ **Weight**: _____

1. 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?_____
2. During the last month how many nights have **you** stayed in a hospital? _____
3. Do **you** have health insurance? Circle the best answer. *NO* *YES*
4. 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…	*All of the Time*	*Most of the Time*	*Some of the Time*	*A Little of the Time*	*None of the Time*
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

If you are in an adult relationship, please complete the following section. If you are not, skip to the next section.

1. Please indicate the degree of happiness, all things considered, of your relationship. Circle the best answer.

Extremely Unhappy	*Fairly Unhappy*	*A Little Unhappy*	*Happy*	*Very Happy*	*Extremely Happy*	*Perfect*
0	1	2	3	4	5	6

	Not at All True	*A Little True*	*Somewhat True*	*Mostly True*	*Completely True*	*Completely True*
2. I have a warm and comfortable relationship with my partner	0	1	2	3	4	5

	Not at All	*A little*	*Some-what*	*Mostly*	*Almost Completely*	*Completely*
3. How rewarding is your relationship with your partner?	0	1	2	3	4	5
4. In general, how satisfied are you with your relationship?	0	1	2	3	4	5

Next Section.

Over the past 4 weeks, **how satisfied have you been**:

	Very Dissatisfied	*Moderately Dissatisfied*	*Equally Satisfied/ Dissatisfied*	*Moderately Satisfied*	*Very Satisfied*
1. With the amount of emotional closeness during sexual activity between you and your partner?	1	2	3	4	5
2. With your sexual relationship with your partner?	1	2	3	4	5
3. How satisfied have you been with your overall sexual life?	1	2	3	4	5

Please mark the most accurate answer applicable for your economic situation each month.

1. At the end of the month we have:

more than enough money left over *some money left over* *Just enough to make ends meet* *not enough to makes ends meet*
1 2 3 4

		Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*
2.	We are able to afford adequate housing, clothing, food, and medical care.....	1	2	3	4

3. How much difficulty have you and your spouse had in paying bills during the past 12 months?
A little difficulty some difficulty quite a bit of difficulty a great deal of difficulty
1 2 3 4

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*
F. 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 including dosage and prescriber

_____

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

Answer the following questions for your **childhood** and the **family in which you grew up**.

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

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

A. Yourself *B. Your Spouse/Partner* *C. One of your Children*

D. 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*