Joseph L. Nines, Ph.D., L.M.F.T.

Licensed Marriage and Family Therapist

215-836-4276

CLIENT INTAKE INFORMATION

Please fill out this form and bring it to your first session. This form, as well as all other information you provide, will be kept strictly confidential and will not be released except with your written consent. This information is necessary to complete your file.

Your Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Partner's Name: _____
(Last) (First) (Middle Initial)

Please list any children with their ages: _____

_____

Home Address: _____
(Street and Number, Apt.)

_____
(City) (State) (Zip)

Home Phone: (_____) _____-_____ May I leave a message? ☐ Yes ☐ No

Cell/Other Phone: (_____) _____-_____ May I leave a message? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐ No
*** Please note: Email correspondence is not considered confidential communication. ***

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ No
☐ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? ☐Yes ☐ No

Please list Name(s) and Dosage(s): _____

_____

Have you ever been prescribed psychiatric medication? ☐Yes ☐ No

Please list and provide name(s), dosage(s) and date(s): _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

2. How would you rate your current sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐Yes ☐ No

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐Yes ☐ No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? ☐Yes ☐ No

If yes, please describe: _____

8. How often do you drink alcoholic beverages?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

9. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐Yes ☐ No

If yes, for how long? _____

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

11. What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Mental Health Issue		**List Family Member**
Alcohol/Substance Abuse	☐Yes ☐ No	
Anxiety	☐Yes ☐ No	
Depression	☐Yes ☐ No	
Domestic Violence	☐Yes ☐ No	
Eating Disorders	☐Yes ☐ No	
Obesity	☐Yes ☐ No	
Obsessive Compulsive Behavior	☐Yes ☐ No	
Schizophrenia	☐Yes ☐ No	
Suicide Attempts	☐Yes ☐ No	

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐Yes ☐ No

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐Yes ☐ No

If yes, describe your faith or belief: _____

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____