

Metropolitan Marriage & Family Therapy, PLLC

Succeed at Your Relationship and Your Life!

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Intake: Confidential Client Information

Date: _____ How Did You Hear About us: _____

Name: _____ AKA: _____

Address: _____

Phone Numbers: Home: _____ Work: _____ Other: _____

E-Mail Address: _____ Date of Birth: _____ Age: _____

I. Occupation: _____

Employer: _____

Education: What is the highest grade completed (degree): _____

Ethnic Origin: _____ Place of Birth: _____

Religion: Raised In: _____ Currently Practicing: _____

How often do you attend religious services at this time?

Frequently _____ Sometimes _____ Never _____

II. What is your approximate yearly household income? \$ _____

Source(s): _____

III. You are currently (check each status that applies to you and give approximate dates):

Single _____ Single Actively Dating _____ Single Involved _____

Engaged _____ Date _____

Married _____ Date _____

Widowed _____ Date _____

Cohabiting _____ Date _____

Separated _____ Date _____

Divorced _____ Date _____

Remarried _____ Date _____

IV. Would you say you are primarily:

- Heterosexual____ (sexually attracted to the opposite sex)
- Gay / Lesbian____ (sexually attracted to the same sex)
- Bisexual____ (sexually attracted to either or both sexes)

V. Were you adopted? Yes____ No____

If you were not brought up by your biological parents, who raised you?

VI. Partner Information (if applicable):

Name: _____ AKA: _____

How did you meet? _____

Occupation: _____

Ethnic Origin: _____ Place of Birth: _____

DOB / Age: _____

Education: What is the highest grade completed (degree): _____

Religion: Raised In: _____ Currently Practicing: _____

How often does he / she attend religious services at this time?

Frequently____ Sometimes____ Never____

Was he / she adopted? Yes ____ No____

If not raised by biological parents, who raised them? _____

VII. Information on Children (if applicable):

Please fill in information below in the space indicated. Put "B" for biological children, "A" for adopted children, "F" for foster children, and "S" for step-children.

Name	Birthdate / Age	Gender (M / F)	Grade	Resides with	Relationship (B, A, F, or S)
1)					
2)					
3)					
4)					

Who else is currently living in your household? State name, gender, age and relationship.

VIII. What is your present state of health? Your partner's?

What serious medical illness have you, your partner or your children had & when?

If you have had any of the following experiences, check each that applies to you and indicate dates where possible:

- | | |
|--|--|
| Periods of Depressions_____ | Physical Abuse_____ |
| Use of Alcohol_____ | Sexual Abuse_____ |
| Use of Drugs_____ | Suicide Attempts_____ |
| Mental Illness_____ | Recurring Thoughts of Suicide_____ |
| Unexplainable Fatigue_____ | Erratic Sleeping Patterns_____ |
| Problems with a Child's Behavior, School Adjustment, or Performance_____ | Erratic Eating Patterns_____ |
| Infertility_____ | Relationship Difficulties_____ |
| Loss / Bereavement_____ | Infidelity_____ |
| Sexual problems or concerns_____ | Anxiety, Fears/Phobias, Panic Attacks_____ |
| Feelings of Loneliness, Moodiness, Sadness, Failure, Stress_____ | Difficulties Concentrating/Remembering Things_____ |
| Coping with Chronic Illness_____ | Frequent Financial Difficulty_____ |
| Difficulty in Setting or Reaching Goals_____ | Work Difficulties, Frequent Job Difficulties with Anger, Hostility, or Violence_____ |
| Changes, Problems with Co-Workers_____ | |
| Difficulties talking with significant others_____ | Amount of time spent on the Net_____ |
| Obsessions, addictions_____ | |

IX. Other Pertinent Information:

Have you had problems with the law? Please explain and give dates?

Do you have any court pending cases right now? Please explain and give dates?

Give a brief employment and / or career history:

Who is part of your support group?

X. Therapeutic History and Expectations:

What type of therapeutic treatment have you received, if any?

Individual _____ Couple _____ Family _____ Group _____

Outpatient: _____ Where: _____
When: _____
For How Long: _____
With Whom: _____

Inpatient: _____ Where: _____
When: _____
For How Long: _____
With Whom: _____

Use the back of page to share of multiple experiences.

What was your past therapy experience like?

What are your current expectations for therapy?

What prompted you to seek services at this time?

XI. Family of Origin Information:

A. Mother's Name: _____ **DOB / Age:** _____

Occupation: _____

Ethnic Origin: _____ **Place of Birth:** _____

Education: What is the highest grade completed (degree): _____

Living? Yes _____ **No** _____ **If not, date and cause of death:** _____

Health: _____

Religion: Raised In: _____ Currently Practicing: _____

City / Country of Residence: _____

How often does she attend religious services at this time?

Frequently _____ Sometimes _____ Never _____

Was she adopted? Yes _____ No _____

If not raised by biological parents, who raised them? _____

B. Father's Name: _____ **DOB / Age:** _____

Occupation: _____

Ethnic Origin: _____ Place of Birth: _____

Education: What is the highest grade completed (degree): _____

Living? Yes _____ No _____ If not, date and cause of death: _____

Health: _____

Religion: Raised In: _____ Currently Practicing: _____

City / Country of Residence: _____

How often does he attend religious services at this time?

Frequently _____ Sometimes _____ Never _____

Was he adopted? Yes _____ No _____

If not raised by biological parents, who raised them? _____

C. Were parents married? When? _____

Were parents separated or divorced? How old were you when this happened? _____

Have there been any deaths in the immediate family? Yes _____ No _____

If so, please specify, state your relationship to them and approximate date of death _____

D. Siblings:

Please fill in information below in the space indicated. Put "B" for biological siblings, "H" for half-siblings, "A" for adopted siblings, "S" for step-siblings, and "F" for foster siblings.

	Name	Age	Gender (M / F)	City of Residence	Relationship (B, H, A, S, or F)
1)					
2)					
3)					
4)					
5)					

E. List any family and generational concerns (i.e., substance abuse; sexual and physical abuse; sexual, money, and health issues; anger, depression, anxiety; obsessions; suicidal thoughts; infidelity; eating disorders; others)

XII. Family Impressions:

A. Mother:

Describe your impression of your mother growing up:

Describe your mother's behaviors when you were a child:

List feelings towards her growing up:

How did you behave when around her / toward her when you were a child:

B. Father:

Describe your impression of your father growing up:

Describe your father's behaviors when you were a child:

List feelings towards him growing up:

How did you behave when around him / toward him when you were a child:

C. Experience Growing Up:

How did it feel to be in your family growing up?

What were you like as a child?

Describe your parents' relationship. What were their main behaviors towards each other?

What wish(es) / dream(s) did you have as a child?

D. Your partner:

Describe your partner and your relationship?

What is your primary feelings in your relationship with your partner?

What would you like to be different in your relationship? What behaviors towards you would you change in your partner?

XIII. Additional Information:

Please share any other information that you feel will assist us in assessing your situation and getting to know you better. If you were raised by other than your mother and/or father, or somebody else assisted them in raising you, please describe your relationship with them – be specific.

Thank you for taking the time to thoroughly fill out this form. This information will assist us better service your needs.

Emma K. Viglucci, CFT, LMFT, CIT
Marriage and Family Therapist
Clinical Director
Founder and President