Francine Lapides, MFT
Marriage and Family Therapist
Adult, Couple and Family Counseling
License MFC7414

831-335-4830
474 Fall Creek Dr.
Felton, CA 95018

CLIENT INTAKE FORM

Client Intake Questionnaire

Name	Date
Address	Referred by
Age	Date of Birth
Home Phone	Work Phone
Fax	E-mail
Marital Status	Educational level
Occupation:	Names & Ages of Children
Emergency contact information	
Explanation of how patient may be contacted by therapist	
Psychological History:	
Have you ever received mental health treatment before? ☐ Yes ☐ No	If so, when and for how long?
What was the focus of treatment?	
Name of treating therapist(s), address(es), telephone number(s): (Your signature on an informed consent form is necessary before any former therapist(s) can be contacted.)	
Have you ever been hospitalized for mental or emotional problems? ☐ Yes ☐ No	If so, when and for how long?
Why were you hospitalized?	
Name of treating therapist, address and telephone number: (As above, your signature on an informed consent form is necessary before any former therapist(s) can be contacted.)	
Do you have, or have you ever had, an eating disorder or other problem with food? ☐ Yes ☐ No	
Are you currently taking any prescription medications? ☐ Yes ☐ No	If so, Prescribed by whom?
Have you ever attempted suicide? ☐ Yes ☐ No	If so, when?
Describe the circumstances that led to that attempt?	
Are you currently having any suicidal thoughts? ☐ Yes ☐ No	If so, please describe

Please describe your childhood	
Were you ever subjected to verbal, physical, emotional or sexual abuse? ☐ Yes ☐ No	If so, please describe
Medical History:	
Have you ever been diagnosed with a serious illness? ☐ Yes ☐ No	If so, please describe
Do you have any medical conditions that may affect your mental health treatment? ☐ Yes ☐ No	
Please describe your overall health today	
Are you physically active? ☐ Yes ☐ No	Please describe
Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? ☐ Yes ☐ No	If so, please describe
Have you ever been in a 12-step program? ☐ Yes ☐ No	If so, describe
Do you smoke? ☐ Yes ☐ No	If so, how much and for how long?
Do you drink alcohol? ☐ Yes ☐ No	If so, please describe your use
Have you ever used illegal drugs? ☐ Yes ☐ No	If so, please describe
Family of Origin History:	
Mother's name & age. If deceased, your age at the time of your Mother's death, and description of relationship with Mother	
Father's name & age. If deceased, your age at the time of your Father's death, and description of relationship with Father	
Names and ages of siblings	
Other Information:	
Please describe your spiritual identity or orientation	
Please describe your interests/hobbies	
Are you now, or have you ever been involved in a lawsuit? ☐ Yes ☐ No	If so, please describe
Please take an additional moment and include any other information that you believe is relevant to your mental health treatment, no previously addressed	

For couples: Please note that I have a "no secrets" policy which means that any information shared by one member of the couple outside of the presence of the other member of the couple may be disclosed to the other member of the couple at the therapist's discretion.