



Francine Lapides, MFT

Marriage and Family Therapist
 Adult, Couple and Family Counseling
 License MFC7414

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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.