



MFTI
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Today's date: _____

Note: If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____
Nicknames or aliases: _____
Home street address: _____ Apt.: _____
City: _____ State: _____ Zip: _____
Best Number to Reach You: _____ e-mail: _____
Is it okay to leave a message on your voice mail or on email? Yes No

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____
Address: _____

May I have your permission to thank this person for the referral? Yes No

C. Religious and racial/ethnic identification

Current religious denomination/affiliation Protestant Catholic Jewish Islamic Buddhist Hindu
Other (specify): _____

Involvement: None Some/irregular Active

How important are spiritual concerns in your life? _____

Ethnicity/national origin: _____ Race: _____ or other similar way
you identify yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____
Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

E. Your current employer

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Are you currently a student Y N Fulltime ___ Parttime ___ Grade/Level ___ Expected Grad. Date _____

Last Grade Completed _____ High School Y N College: Y N Graduate School: Y N

Last or Current School _____ Location _____

H. Military experience ? Y ___ N ___ Enlistment Dates: From: _____ to _____

I. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Stepmother	_____	_____	_____
Stepfather	_____	_____	_____
Grandparents	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Others	_____	_____	_____
	_____	_____	_____

J. Marital/Relationship history

Single In a Relationship Married Separated Divorced Widowed Remarried

Name of Significant other _____ Age _____
Date Relationship Began _____ Date of Marriage _____
Date of Separation/Divorce/Death/ Relationship End _____

If divorced, has ex-spouse remarried? _____

K. Children Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age	Sex	School	Grade

L. Chief concern

Please describe the main difficulty that has brought you to see me: _____

M. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

No Yes If yes, please indicate:

1.Name of provider: _____

Address of provider: _____

Phone number: _____

Dates of Service _____

Can I contact this provider to better coordinate care? Y_____ N_____

2.Name of provider: _____

Address of provider: _____

Phone number: _____

Dates of Service _____

Can I contact this provider to better coordinate care? Y_____ N_____

N. Medications

Name	Dose	Purpose	Date From	Side Effects/Concerns

O. Relationships in your family of origin.

Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with any other adults present: _____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____

4. Your relationship with your brothers and sisters, in the past and present: _____

P. History of Abuse ? ____Y ____N Physical Sexual Emotional Verbal Neglect

Explain: _____

Q. Chemical use

- 1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? _____.
How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? _____
How many "energy drinks"? _____ How often do you use No Doz or similar caffeine pills? _____.
 - 2. How much tobacco do you smoke or chew each week? _____
 - 3. Have you ever felt the need to cut down on your drinking? No Yes
 - 4. Have you ever felt annoyed by criticism of your drinking? No Yes
 - 5. Have you ever felt guilty about your drinking? No Yes
 - 6. Have you ever taken a morning "eye-opener"? No Yes
 - 7. How much beer,wine,or hard liquor do you consume each week,on the average? _____
 - 8. Are there times when you drink to unconsciousness,or run out of money as a result of drinking? No Yes
 - 9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? No Yes If yes, which and when? _____
- Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
- _____
- _____

Please provide details about your use of these drugs or other chemicals,such as amounts,how often you used them, their effects,and so forth: _____

R. Legal history

- 1. Are you presently suing anyone or thinking of suing anyone? No Yes. If yes, please explain: _____

- 2. Is your reason for coming to see me related to an accident or injury? No Yes If yes,please explain: _____

- 3. Are you required by a court, the police, or a probation/parole officer to have this appointment? No Yes. If yes, please explain: _____

S. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: _____
