

THERAPIST # _____

CASE # _____

PFEIFFER INSTITUTE (PIMFT)
CLIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ (Home Work Cell) OK to leave message? Yes No

Alternate Phone: _____ (Home Work Cell) OK to leave message? Yes No

Recognizing that electronic communication may not always be secure, will you allow Pfeiffer Institute to email you regarding scheduling and referral information? Yes No

If **yes**, please provide your preferred email address: _____

Current Concerns: What brings you to the Pfeiffer Institute? For each problem you identify, please list <i>when the problem began</i> and <i>how distressed</i> you have been by that problem.					
Problem	When it began	Distress Level			
		A little	Moderate	Quite a bit	Extreme
		1	2	3	4
		1	2	3	4
		1	2	3	4

Please list all medications you are taking, <i>including over-the-counter or herbal medications</i> :				
Medication	Dosage	Prescribing Doctor	Date Started	Reason Taking

Please list everyone who currently lives in your in household:

Name: _____ Male Female Age: _____ Relationship to you: _____

Name: _____ Male Female Age: _____ Relationship to you: _____

Name: _____ Male Female Age: _____ Relationship to you: _____

Name: _____ Male Female Age: _____ Relationship to you: _____

Name: _____ Male Female Age: _____ Relationship to you: _____

Please provide the following information about yourself by checking the boxes that apply:

Date of Birth: mm/dd/yyyy _____

Current age: _____

What is your gender?

- 1. Male
- 2. Female
- 3. Other

What is your sexual orientation?

- 1. Heterosexual
- 2. Gay / Lesbian
- 3. Bisexual
- 4. Other: _____

What language do you prefer to speak in therapy?

- 1. English
- 2. Spanish
- 3. Other: _____

What is your racial or ethnic origin?

- 1. American Indian or Alaska Native
- 2. Asian or Pacific Islander
- 3. African-American / Black
- 4. Caucasian / White
- 5. Latino/a
- 6. Biracial or Multiracial: _____
- 7. Other: _____

What is your religious preference?

- 1. Catholic
- 2. Protestant (Baptist, Methodist, etc.)
- 3. Latter-Day Saint (Mormon)
- 4. Jewish
- 5. Muslim
- 6. Other (specify): _____
- 7. None

Do you have any children?

- 1. No
- 2. Yes How many? _____

What is the highest level of education that you have completed?

- 1. Grade school
- 2. High school (or GED)
- 3. Some college
- 4. Bachelor's degree
- 5. Graduate Student
- 6. Master's degree
- 7. Doctorate degree

What is your employment status?

- 1. Employed full-time
Occupation: _____
- 2. Employed part-time
Occupation: _____
- 3. Unemployed
- 4. Homemaker
- 5. Retired
- 6. Student

What is your current annual income?

- 1. Less than \$10,000
- 2. \$10,000 – \$19,999
- 3. \$20,000 – \$29,999
- 4. \$30,000 – \$39,999
- 5. \$40,000 – \$49,999
- 6. \$50,000 – \$59,999
- 7. \$60,000 – \$69,999
- 8. \$70,000 or above

What is your current relationship status?

- 1. Single, never married, not dating
- 2. Single, divorced or separated
- 3. Single, widowed
- 4. Dating
- 5. Living together
- 6. Engaged to be married
- 7. Married, first marriage
- 8. Married, second or third marriage

How long have you been in this current relationship?

On the following checklist, please indicate problems that are a concern to you about **YOURSELF**:

- 1. chronic illness/pain
- 2. depression
- 3. anxiety/worries
- 4. stress
- 5. sexual abuse / rape
- 6. eating disorder
- 7. relationship problem
- 8. physical problem
- 9. excessive alcohol/drugs
- 10. family relationships
- 11. sexual problems
- 12. parenting
- 13. self-esteem
- 14. lack of assertiveness
- 15. suicidal thoughts
- 16. anger
- 17. grief
- 18. self-injury / self-mutilation
- 19. sexual addiction
- 20. emotional abuse in childhood
- 21. physical abuse in childhood
- 22. sexual abuse in childhood
- 23. other (please specify) _____

Problems that are a concern to you about **YOUR PARTNER**:

- 1. chronic illness/pain
- 2. depression
- 3. anxiety/worries
- 4. stress
- 5. sexual abuse / rape
- 6. eating disorder
- 7. relationship problem
- 8. physical problem
- 9. excessive alcohol/drugs
- 10. family relationships
- 11. sexual problems
- 12. parenting
- 13. self-esteem
- 14. lack of assertiveness
- 15. suicidal thoughts
- 16. anger
- 17. grief
- 18. self-injury / self-mutilation
- 19. sexual addiction
- 20. emotional abuse in childhood
- 21. physical abuse in childhood
- 22. sexual abuse in childhood
- 23. other (please specify) _____

Problems that are a concern to you about **YOUR RELATIONSHIP**:

- 1. poor communication.
- 2. argue about finances.
- 3. not enough time together.
- 4. fighting/arguing.
- 5. physical violence.
- 6. excessive alcohol/drugs.
- 7. refuses sex too often.
- 8. demands sex too often.
- 9. physical sexual problems (impotence, painful intercourse, etc.).
- 10. parenting differences.
- 11. partner too controlling.
- 12. different values.
- 13. emotional abuse.
- 14. difficulties with in-laws/extended family
- 15. other (please specify): _____

Problems that are a concern to you about your **CHILDREN/FAMILY**:

- 1. stealing
- 2. fire setting
- 3. truancy
- 4. fighting
- 5. drugs/alcohol
- 6. adolescent pregnancy
- 7. sexual abuse (victim)
- 8. sexual abuser
- 9. disobedience
- 10. divorce adjustment
- 11. death in family
- 12. anger
- 13. peer relationships
- 14. poor self-esteem
- 15. bed-wetting/soiling
- 16. destructiveness
- 17. issues with stepchildren/stepparenting
- 18. eating disorder
- 19. self-injury / self-mutilation
- 20. other (please specify) _____

Problems that occurred *IN THE HOUSEHOLD(S) IN WHICH YOU WERE RAISED BEFORE AGE 18:*

- 1. alcohol/drug addiction
- 2. physical abuse
- 3. emotional/verbal abuse
- 4. unwanted touching
- 5. financial problems
- 6. sexual abuse
- 7. divorce
- 8. lived in foster home
- 9. emotional distance
- 10. other (please specify) _____

Problems that occurred *TO YOU BEFORE AGE 18:*

- 1. alcohol/drug addiction
- 2. physical abuse
- 3. emotional/verbal abuse
- 4. unwanted touching
- 5. financial problems
- 6. sexual abuse
- 7. divorce
- 8. lived in foster home
- 9. emotional distance
- 10. other (please specify) _____

Do you have any concerns about your weight?

- Yes No

If yes, please describe

Have you struggled with an eating disorder?

- Yes No

If yes, which one(s)?

- 1. Anorexia
- 2. Bulimia
- 3. Binge Eating
- 4. Obesity

How long (length of time)? _____

In general, how often do you drink alcohol?

- 1. Never
- 2. Less than once a month
- 3. About once a week
- 4. 2 to 3 days per week
- 5. 4 to 6 days per week
- 6. Daily

Do you drink more now than you used to?

- Yes No

Has anyone objected to your drinking? Yes No

In general, how often do you use recreational or illicit drugs?

- 1. Never
- 2. Less than once a month
- 3. About once a week
- 4. 2 to 3 days per week
- 5. 4 to 6 days per week
- 6. Daily

What drugs do you use? _____

Do you use drugs more often than you used to?

- Yes No

Has anyone objected to your drug use? Yes No

When was the last time you drank alcohol or used drugs?

In general, how often do you use tobacco products?

- 1. Never
- 2. Less than once a month
- 3. About once a week
- 4. 2 to 3 days per week
- 5. 4 to 6 days per week
- 6. Daily

Do you use tobacco products more often than you used to? Yes No

Has anyone objected to your tobacco use? Yes No

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling.

Read each item carefully and put a check under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

Outcome Questionnaire (OQ – 45.2)	Almost always	Frequently	Sometimes	Rarely	Never
1. I get along well with others					
2. I tire quickly.					
3. I feel no interest in things					
4. I feel stressed at work/school.					
5. I blame myself for things.					
6. I feel irritated.					
7. I feel unhappy in my marriage/significant relationship.					
8. I have thought of ending my life.					
9. I feel weak.					
10. I feel fearful.					
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”)					
12. I find my work/school satisfying.					
13. I am a happy person.					
14. I work/study too much.					
15. I feel worthless.					
16. I am concerned about family troubles					
17. I have an unfulfilling sex life.					
18. I feel lonely.					
19. I have frequent arguments.					
20. I feel loved and wanted.					
21. I enjoy my spare time.					
22. I have difficulty concentrating.					
23. I feel hopeless about the future.					
24. I like myself.					
25. Disturbing thoughts come into my mind that I cannot get rid of.					
26. I feel annoyed by people who criticize my drinking (or drug use).					
27. I have an upset stomach.					

Outcome Questionnaire (OQ – 45.2)	Almost always	Frequently	Sometimes	Rarely	Never
28. I am not working/studying as well as I used to.					
29. My heart pounds too much.					
30. I have trouble getting along with friends and close acquaintances.					
31. I am satisfied with my life.					
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark “never”)					
33. I feel that something bad is going to happen.					
34. I have sore muscles.					
35. I feel afraid of open spaces, of driving, or being on buses, subways and so forth.					
36. I feel nervous.					
37. I feel my love relationships are full and complete.					
38. I feel that I am not doing well at work/school.					
39. I have too many disagreements at work/school.					
40. I feel something is wrong with my mind.					
41. I have trouble falling asleep or staying asleep.					
42. I feel blue.					
43. I am satisfied with my relationships with others.					
44. I feel angry enough at work/school to do something I might regret.					
45. I have headaches.					

Complete the following questionnaire if you are in a relationship with a significant other (e.g., spouse, partner, boyfriend, girlfriend)

<i>Most persons have disagreements in their relationships. Please indicate the degree of agreement or disagreement between you and your partner for each item on the following list.</i>						
DAS-R	Always agree	Almost always agree	Occasionally disagree	Frequently disagree	Almost always disagree	Always disagree
1. Religious matters						
2. Demonstrations of affection						
3. Making major decisions						
4. Sex relations						
5. Conventuality (correct or proper behavior)						
6. Career decisions						

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?						
8. How often do you and your partner quarrel?						
9. Do you ever regret that you married (or lived together)?						
10. How often do you and your partner “get on each other’s nerves”?						
		Every Day	Almost Every Day	Occasionally	Rarely	Never
11. How often do you and your partner engage in outside interests together?						
How often would you say the following events occur between you and your partner?	More than once a day	Once a day	Once or twice a week	Once or twice a month	Less than once a month	Never
12. Have a stimulating exchange of ideas?						
13. Work together on a project?						
14. Calmly discuss something?						

Thank you for taking the time to accurately complete this intake information packet!