THERAPIST #_____ CASE #_____

PFEIFFER INSTITUTE FOR MARRIAGE AND FAMILY THERAPY

CHILD INFORMATION

*Please print clearly and **check** the answers that apply:*

Legal Guardian Information:

Name: _____ Today's Date: _____

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

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

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

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

Date of Birth: mm/dd/yyyy _____ Age: _____

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: _____

In the case of an emergency, is there a secondary legal guardian that we may contact?

Name: _____ Phone: _____ Relation to child: _____

Child Information:

Name: _____ Date of Birth: mm/dd/yyyy _____ Age: _____

Current school grade level: _____

Please list **ALL MEDICATIONS** your child is taking below, ***including over-the-counter or herbal medications***:				
Medication	Dosage	Prescribing Doctor	Date Started	Reason Taking

Current Concerns: What brings your child to the Pfeiffer Institute? For each problem you identify, please list ***when the problem began*** and ***how distressed*** your child has 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

How would you rate your child's performance at school?

- ❑ 1. Excellent
- ❑ 2. Good
- ❑ 3. Average
- ❑ 4. Poor

On average, how much television (including video games) does your child watch (play) per week?

- ❑ 1. 0-3 hours
- ❑ 2. 4-6 hours
- ❑ 3. 6-9 hours
- ❑ 4. Over 9 hours

Has your child taken any illegal drugs or alcohol?

❑ Yes ❑ No

How long ago? _____

Is your child still actively using?

❑ Yes ❑ No

Do you have any concerns about your child's weight?

❑ Yes ❑ No

If yes, please describe. _____

Has your child 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)? _____

Please provide the following information about <u>yourself</u> (legal guardian)by checking the boxes that apply:

What is your gender?
- ❑ 1. Male
- ❑ 2. Female
- ❑ 3. Other

What is your sexual orientation?
- ❑ 1. Heterosexual
- ❑ 2. Gay / Lesbian
- ❑ 3. Bisexual

What language do you prefer to speak in therapy?
- ❑ 1. English
- ❑ 2. Spanish
- ❑ 3. Other: _____

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 religious preference?
- ❑ 1. Catholic
- ❑ 2. Protestant
- ❑ 3. Latter-Day Saint (Mormon)
- ❑ 4. Jewish
- ❑ 5. Other (specify): _____
- ❑ 6. None

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 racial or ethic origin?
- ❑ 1. American Indian or Alaska Native
- ❑ 2. Asian or Pacific Islander
- ❑ 3. African-American / Black
- ❑ 4. Caucasian / White
- ❑ 5. Mexican-American / Hispanic
- ❑ 6. Biracial: _____
- ❑ 7. Other: _____

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) _____

Please answer the following questions based on **your experience** with the Pfeiffer Institute:					
	Strongly Agree	**Agree**	**Unsure**	**Disagree**	**Strongly Disagree**
1. The Pfeiffer Institute was easy to access.	5	4	3	2	1
2. The scheduling of my appointment was easy and simple.	5	4	3	2	1
3. I received an appointment in a timely manner.	5	4	3	2	1
4. My therapist was on time for my appointment.	5	4	3	2	1

How did you learn about the Pfeiffer Institute?

- ❑ 1. I am a former client
- ❑ 2. Friend / Family Member
- ❑ 3. Employer
- ❑ 4. Physician
- ❑ 5. Website
- ❑ 6. Other: _____
- ❑ 7. Another Professional Name: _____

  May we contact him/her? ❑ 1. Yes ❑ 2. No

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