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Intake Questionnaire

Name ______________________________ Date______________________________

Date of birth ______________________________ Age ______________________________

Address ______________________________ Home phone ______________________

Cell phone ______________________________ Work phone ______________________

E-mail ______________________________ Referred by ______________________

Occupation ______________________________ Employer ______________________

Education level ______________________________ SSN ______________________________

Relationship status ______________________ Partner's name __________________

Emergency contact name/relationship/number

____

Best way to contact you ____

Any numbers I should not leave messages at _______________________________

Financial Information

If planning to use health insurance:

Name of Insurance Company ____

Name of Primary Insured____

Primary Insured's Social Security Number___________________________________

Primary Insured's Address____

Primary Insured's Phone Number____

Primary Insured's Birth Date____

Primary Insured's Employer ____

Policy # ______________________________ Group # ______________________

Member ID ______________________________ Authorization # ___________________

Areas of Concern

Please write “P” for past “C” for current/recent symptoms or issues:

____ Anger
____ Aggression
____ Physical Fights
____ Change in Appetite
____ Stomachaches
____ Nausea
____ Fatigue
____ Lack of energy
____ Lack of motivation
____ Feeling hopeless
____ Increase in sleep
____ Sadness
____ Isolation
____ Loneliness
____ Excessive crying
____ Depression
____ Suicidal thoughts
____ Cutting or self harm
____ Feeling helpless
____ Suicide attempt
____ Sexual Identity
____ Sexual Orientation
____ Financial problems
____ Poor concentration
____ Insomnia

____ Elevated Mood
____ Excessive Energy
____ Body image concerns
____ Restricting food
____ Worrying about food
____ Overeating
____ Purging
____ Weight gain/loss
____ Headaches
____ Irritability
____ Impulsive behavior
____ Military issues
____ Relationship problems
____ Work/school problems
____ Family problems
____ Difficulty with friends
____ Alcohol abuse/problems
____ Drug abuse/problems
____ Infidelity
____ Sexual dysfunction
____ Car or other accident
____ Chronic pain
____ Major life change
____ Major illness
____ Fear of hurting someone

____ Anxiety
____ Worries/fears
____ Obsessions
____ Compulsions
____ Racing thoughts
____ Panic attacks
____ Fear of dying
____ Avoiding things/places
____ Rituals/counting/touching
____ Difficulty trusting others
____ Homicidal thoughts
____ Arguments with others
____ Decreased need for sleep
____ Family/friend suicide
____ Intimate partner violence
____ Physical abuse
____ Sexual abuse
____ Sexual assault
____ Emotional abuse
____ Flashbacks
____ Other traumatic experience
____ Seeing things others don’t see
____ Hearing voices
____ Nightmares
____ Death/illness of loved one

Other concerns not listed that you would like me to know about:

____

Reason for seeking therapy at this time:

____

____

What you hope therapy can help you with:

____

____

Psychological History

Have you seen a therapist before? **Yes ___ No ___**
If yes, please list name of therapist and time period seen

____

Name of therapist   Dates of therapy   Reason for therapy

Reason for ending treatment:

____

____
Name of therapist   Dates of therapy   Reason for therapy

Reason for ending treatment:

____

What has been helpful or not helpful in past therapy?

____

____

Have you ever had psychological testing? **Yes ___ No ___**
If yes, please list name of the person who did the testing and dates of testing:

____

Current medications and doses:

____

Reasons for medications:

____

Doctor prescribing these medications:

____

Past medications taken for mental health issues/reasons they were discontinued:

____

Have you ever been psychiatrically hospitalized? **Yes ___ No ___**
If yes, please list name of hospital, date, and reason for hospitalization:

____

____

Have you ever attended a partial hospital program or substance abuse treatment program?

Yes ___ No___ If so, please list name of program and dates:

____

Have you ever received treatment for an eating disorder? **Yes___ No___**
If yes, please list therapist/facility and dates:

____

Have you ever attempted suicide? **Yes___ No___**

If yes, please describe the circumstances that led to the attempt, people who knew, and how it was handled: ____

____

____

Have you ever had a family member attempt or complete suicide? **Yes___ No___**

Are you currently experiencing any thoughts of suicide? **Yes___ No___**

Medical History/Health

____

Name of primary care doctor address phone number

____

Name of psychiatrist or other specialist address phone number

Please list any current health concerns/medical issues:

____

Past surgeries or hospitalizations: ____

____

Allergies: ____

Average number hours of sleep: ____ Typical sleep hours: ___________ to ________________

Do you exercise? **Yes ___ No___** If yes, please list type and frequency:

____

Current Family Situation

Names and ages of children if any:

____

____

Other people living in the home:

____

Who do you get along with best in the family and why?

____

Things you like about your family:

____

Things you would like to see change in your family:

Family of Origin

Who did you grow up with and where? (Please list names and current ages if still alive)

Describe your relationships with these family members while growing up:

Describe your current relationships with these family members:

Other Information

What concerns do you think the people in your life have about you now?

Who are the people in your life you can go to for support?

What are your hobbies and interests?

What do you identify as your cultural/ethnic background?

What do you identify as your spiritual/religious identity/orientation?

What do you identify as your sexual orientation? (heterosexual, homosexual, bisexual etc.)

What do you identify as your sexual identity? (female, male, transgender etc.)

Anything else you would like me to know about you: