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Intake Questionnaire

Name _____ Date_____

Date of birth _____ Age _____

Address _____ Phone number_____

_____ Gender _____

E-mail _____ Referred by _____

Employer _____ Occupation _____

School _____ Major_____

Relationship status _____ Partner's name _____

Emergency contact name/relationship/number

_____

Preferred pronouns: _____

Financial Information

Do you have **more than one** health insurance plan? _____

If planning to use health insurance:

Name of primary insurance _____

Name of primary insured_____

Relationship to the primary insured_____

Address for primary insured_____

Primary insured's date of birth_____ Primary insured's phone number_____

Primary insured's employer _____

Member ID _____ Group # _____

Name of secondary insurance if applicable _____

Areas of Concern

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

____ Anger	____ Aggression	____ Anxiety
____ Sadness	____ Isolation	____ Worries/fears
____ Decreased Appetite	____ Loneliness	____ Obsessions
____ Increased Appetite	____ Suicidal thoughts	____ Compulsions
____ Stomachaches	____ Cutting/self-harm	____ Racing thoughts
____ Nausea	____ Suicide attempt	____ Panic attacks
____ Fatigue	____ Depression	____ Insomnia
____ Lack of energy	____ Excessive crying	____ Avoiding things/places
____ Lack of motivation	____ Weight loss	____ Nightmares
____ Feeling hopeless	____ Feeling helpless	____ Difficulty trusting others
____ Increased sleep	____ Impulsive behavior	____ Homicidal thoughts
____ Elevated mood	____ Irritability	____ Arguments with others
____ Increased energy	____ Relationship problems	____ Decreased need for sleep
____ Over eating	____ Work/school problems	____ Headaches
____ Body image concerns	____ Family problems	____ Intimate partner violence
____ Restricting food	____ Difficulty with friends	____ Physical abuse
____ Purging	____ Alcohol problems	____ Sexual abuse
____ Worries about food	____ Substance problems	____ Sexual assault
____ Gender identity	____ Infidelity	____ Emotional abuse
____ Sexual orientation	____ Sexual dysfunction	____ Flashbacks
____ Mood swings	____ Hearing/seeing things	____ Other trauma
____ Military combat	____ Physical fights	____ DUI
____ Financial problems	____ Major life change	____ Pornography
____ Difficulty concentrating	____Weight gain	____ Rituals/counting/touching
____ Fear of dying	____ Fear of hurting someone	____ Death/illness of loved one

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

_____

_____

What prompted you to come to therapy at this time?

_____

_____

What would you like to see change in your life?

_____

_____

_____

Psychological History

Have you seen a therapist before? **Yes ___ No ___**

_____

Name of therapist dates of therapy focus of treatment

Reason for ending treatment:

_____

_____

Name of therapist dates of therapy focus of treatment

Reason for ending treatment:

_____

What has been helpful or not helpful in past therapy?

_____

_____

Please list any current medications you are taking:

_____:

_____

Doctor prescribing these medications:

_____

Past medications taken: _____

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

_____

_____

Current use of alcohol and other substances (amount and frequency):

_____

_____

Do you think you may have disordered eating or an eating disorder? **Yes___ No___**

If yes, please share concerns:

_____

Have you ever been arrested? _____

If so, date and offense?

_____

Have you ever attempted suicide? **Yes___ No___**
If yes, did you receive treatment?

_____

_____

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

Current health concerns/medical issues:

_____

Past surgeries or hospitalizations: _____

_____

Food, medication or other types of allergies:

_____

Average number hours of sleep: ____ Typical sleep hours: _____ to _____
Do you exercise? **Yes ___ No___** If yes, please list type and average frequency:

_____

Family or Roommates

Who do you live with and how do you feel about your living situation?

_____

_____

_____

Who can you rely on for support?

_____

Family of Origin

Who did you grow up with? (Please list names and ages)

_____

_____

_____

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?

_____

_____

What are your hobbies and interests?

Clubs or organizations you are affiliated with:

_____

What do you identify as your cultural/ethnic background?

_____

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

_____

How do you identify your sexual orientation?

_____

Anything else you would like me to know about you:

_____

_____