INTAKE QUESTIONNAIRE

NAME: _____ DATE: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: (H) _____PHONE: (W) _____

PHONE: (C) _____ E-MAIL: _____

For confidentiality, when and how do you prefer to be reached? _____

Can We Leave a Message? ☐Yes ☐No

Current Marital status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced

Date of Birth: _____

Spouse's or Partner's Name: _____

Number of Children and ages: _____

Presently living with: ☐Parents ☐Spouse ☐Partner ☐Roommate ☐ Alone ☐Other

_____

Emergency Contact: Name _____ Phone _____

Who referred you or how did you hear about us? _____

REASONS FOR SEEKING HELP

What concerns brought you here today?

_____

_____

_____

_____

_____

When did your present concern(s) first become a worry for you or others?

Please rate the severity of your present concerns on the following scale: (Check one)

☐Mild ☐Moderate ☐Severe ☐Completely Incapacitating

PLEASE INDICATE WHICH OF THE FOLLOWING AREAS ARE CURRENT PROBLEMS FOR YOU: (Check all that apply)

☐Under too much pressure/feeling stressed
☐Angry outbursts
☐Excessive anxiety or worry
☐Difficulty making or keeping friends
☐Feeling as if you'd be better off dead
☐Feeling controlled by others
☐Concerns about physical health
☐Relationship Difficulties
☐Angry feelings
☐Concerns about finances Feeling "numb" or cut off from emotions
☐Excessive fear of specific places/objects
☐Feeling that people are "out to get you"
☐Difficulty making decisions
☐Sexual issues
☐Feeling lonely
☐Feeling sad/frequent crying

☐Other (Please specify):

MEDICAL/HEALTH INFORMATION

☐Blackouts or temporary of loss of memory
☐Change in appetite
☐Abuse of alcohol and/or non-prescription drugs
☐Difficulty concentrating
☐Crying spells
☐Loss of interest in usual activities
☐Obsessions or compulsions
☐Sleep problems
☐Issues with food and/or weight
☐Hallucinations
☐Hearing voices
☐Nightmares
☐Lack of motivation
☐Difficulty controlling thoughts

Date of last physical examination: _____/_____/_____

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems) ☐Yes ☐No If yes, please explain:

Please list names of any previous counselors or therapists, including dates and contact number:

How do you feel about the results of your previous counseling?

Have you ever been hospitalized for psychiatric purposes? If yes, please explain including name of hospital, location and dates:

What do you hope to gain from psychotherapy?

OCCUPATIONAL/EDUCATIONAL INFORMATION

Occupation _____

Employer _____

If Currently a Student: Field of Study _____

☐Part-Time ☐Full-time School Name _____