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Confidential Intake Questionnaire

Client Name: _____Age: _____ Date: _____

Please complete this form to help me as I speak with you regarding treatment. If you are unsure about how to respond to any of these questions, please discuss them with me.

Address:**_____City:_____Zip:_____**

Home Phone:_____ Cell Phone:_____

Work Phone: _____

May I leave a message at (please check if YES): _____Home _____ Cell _____ Work

Date of Birth:_____Place of Birth:_____

Email: _____

May I send you an email message? No Yes

Reason You Are Here:

Briefly describe the problem:

_____

_____

_____

When did the problem start?

_____

What prompted you to seek professional assistance at this time?

_____

_____

Family Information: Circle all that apply

Single, Living Together, Married, Partnered, Engaged, Separated, Divorced, Widowed, Other

Number of Previous Marriages: _____

Name of Spouse/Partner: _____Years together_____

Children/Others Living in the Home - Name(s) and Age(s):

_____

_____

Is your mother living? _____ Mother's age: _____

If not, your age at mother's death: _____ Your mother's age at death? _____

Is your father living? _____ Father's age: _____

If not, your age at father's death: _____ Your father's age at death? _____

Number/Name(s) of brothers: _____ Number/Names(s) of sisters: _____

Your position in the family: _____

Which of the following best describes the family in which you grew up?

Warm and Accepting			Average					Distant, Hostile and Fighting
1	2	3	4	5	6	7	8	9

Was the family/home disrupted by serious illness/accident/death/separation or divorce?

No Yes If yes, please describe

_____

_____

Employment:

Occupation: _____ Employer: _____

Current Employment: _____ Full-time _____ Part-time

_____ Self-employed _____ Unemployed

_____ Student _____ Homemaker

_____ Veteran

Medical/Lifestyle History:

Current health: Poor Fair Good Excellent

Medication(s) currently used*:* _____

Medication/Dose Date Prescribed Why Prescribed Prescribing Physician

Are you currently under the care of a general practitioner and/or psychiatrist? No Yes

If yes, please list name and phone number(s) below:

_____

Past Hospitalizations (Psychiatric/Chemical Dependency):

Date(s): Reasons:

Alcohol use:

How often do you use alcohol? None, Monthly, Weekly, Daily

On the days that you drink, how many drinks do you usually have?

Less than 2, 2-5, 5 or more, How many?

Do you consider it a problem? No Yes

Do others consider it a problem? No Yes

Do you have problems at work/school because of drinking or drug use? No Yes

Have you had problems with alcohol in the past? No Yes

Nicotine use:

Do you smoke or use tobacco now? No Yes

How much? _____How long? _____

Have you smoked or used tobacco in the past? No Yes

How much? _____ How long? _____

Drug use:

Marijuana: None, Occasionally, Daily, Weekly

Do you use other non-prescription substances? If yes, what substance? _____

How often? Occasionally, Daily, Weekly

Mental Health:

Is there a family history of (check all that apply):

Alcoholism, Substance Abuse, Mental Illness, Suicide

If yes, please describe the relationship to you and the problem:

_____

Have you attempted suicide? No Yes

Do you currently have suicidal thoughts? No Yes

Have you had suicidal thoughts in the past? No Yes

Do you every feel angry enough at home, work, or while at school to do something you might regret?

No Yes

If yes, explain:

Childhood History:

As a child did you have any problems with:			**Age**
Learning disabilities	No	Yes	_____
Hyperactivity	No	Yes	_____
Bed wetting	No	Yes	_____
School fears	No	Yes	_____
Depression	No	Yes	_____
Sexual or physical abuse	No	Yes	_____
Emotional abuse	No	Yes	_____
Neglect	No	Yes	_____

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?

No Yes If so, please describe: _____

_____

Legal History: None Litigation Arrest Victimization, specify _____

Previous Counseling, EAP, or Chemical Dependency Services:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy	No	Yes	Marital/Couples Therapy	No	Yes
Group Psychotherapy	No	Yes	Sex Therapy	No	Yes
Alcohol or Substance Abuse	No	Yes			

If yes, please list:

Facility/Counselor Name	Dates Seen	Reason Seen	Helpful?	
_____	_____	_____	No	Yes
_____	_____	_____	No	Yes
_____	_____	_____	No	Yes

CHECKLIST

Please check all of the following problems/symptoms that apply to you within the last 4 weeks:

[ ] sad mood
[ ] feel hopeless
[ ] feel helpless
[ ] overwhelmed
[ ] feel very frustrated
[ ] feel inadequate
[ ] feel guilty
[ ] feel worthless, like a failure
[ ] loss of motivation
[ ] procrastination
[ ] significant weight loss
[ ] problems falling asleep
[ ] difficulty staying asleep
[ ] sleep too much
[ ] withdrawal
[ ] Change in personality
[ ] mood swings
[ ] think I can do almost anything
[ ] criticize myself too much
[ ] neglect my health
[ ] memory problems, forgetful
[ ] problems concentrating or indecision
[ ] cry more than usual
[ ] loss of interest in social activities
[ ] loss of interest in work
[ ] loss of interest in domestic chores
[ ] slowed down, low energy level, fatigue
[ ] change in appetite
[ ] increased irritability
[ ] increased anger, resentment
[ ] easily upset/hurt or too sensitive
[ ] seasonal variations in mood
[ ] tearfulness
[ ] need much less sleep
[ ] racing thoughts or ruminations
[ ] very distractible

[ ] increase in talkativeness
[ ] very high level of energy
[ ] reckless behavior
[ ] feel little need to sleep

Emergency Contact Information:

Name: _____Phone: _____

Address: _____

Relationship to You: _____

Thank you for taking the time to complete this client information form. I look forward to talking with you about it during our counseling sessions.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Name Printed (if client is a minor) Date

_____ _____
Parent/Guardian Signature (if client is a minor) Date

What are your goals/desires/expectations for therapy? What do you hope to gain from therapy? Please explain below: