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Intake Questionnaire

Please complete this form and bring it with you to our first visit.

Name: _____ SSN: _____

DOB: _____ Age: _____ Today's Date: _____

Address: _____

Home Phone: _____ OK to leave a voicemail? Yes No

Cell Phone: _____ OK to leave a voicemail? Yes No

Email: _____ OK to email for appts? Yes No

How did you find out about me?

Psychology Today Website Referral _____

Emergency Contact

Name: _____ Relationship _____

Address: _____

Home Phone: _____ Cell Phone: _____

Personal Information

Relationship Status (circle one or more)

Single Dating Partnered Married Separated Divorced Widowed Other_____

How long have you been the above status? _____

Living situation (select one)

___Alone With others (please specify name, age, relationship) _____

_____

Do you have children? (names, ages, living with you?) _____

_____

Have any of your parents passed away? (circle one) Yes No

If a parent passed away, when and who? _____

Do you have siblings? (circle one) Yes No

How many and how old? _____

Highest Level of Education Completed (circle one)

GED High School Associate's Bachelor's Master's Doctorate

Professional Certification Other

Education – in school currently? (circle one) Yes No

Name of Institution _____ Area of Study _____

Student Status (circle one if applicable) Full Time Part Time Continuing Education

Employment – working currently? (circle one) Yes No

Company _____ Type of Work _____

Employment Status (circle one if applicable) Full Time Part Time # Hours/week _____

Personal and Family History

Emotional Wellbeing (circle for personal history, make an X for family history)

___Academic Problems ___Addiction Problems ___Anxiety ___ADHD ___Bipolar Disorder

___Body Image Distress ___Depression ___Disordered Eating ___Obsessions/Compulsions

___Physical/Medical Health Concern ___Suicide or Attempts ___Trauma

Other_____

Are your parents (circle one)

Married Separated Divorced Remarried Other_____

Past Experiences

Have you ever been a victim of a crime? (circle one) Yes No Unsure

Have you ever experienced a physical trauma? (circle one) Yes No Unsure
(car accident, assault, abuse, etc.)

Have you ever experienced an emotional trauma? (circle one) Yes No Unsure
(victim of crime, abuse, loss or death of a close loved one, etc.)

Have you ever experienced a sexual trauma? (circle one) Yes No Unsure
(sexual harassment, assault, inappropriate touching, etc.)

Have you ever been arrested or convicted of a legal violation? (circle one) Yes No Unsure

Medical Information

PCP Name _____ Clinic: _____

Phone _____

Address _____

Current Prescriptions (name & dose) _____

_____

Current Over the Counter Medications (i.e. melatonin, name & dose) _____

_____

Substance Use (type, quantity, frequency, purpose, and is this something you wish to change)
(i.e. "Black tea, 16oz, daily, use for flavor and energy, I'm happy with my use" or "Craft beer, 32oz, 2 nights/week, use for stress relief and social, my use has increased and I wish it was less")

Caffeine _____

_____

Alcohol _____

_____

Nicotine _____

_____

Marijuana _____

_____

Other _____

_____

Presenting Concerns

___Academic/Work Problems
___Addiction Problems
___Adjusting to School/Work
___Alcohol Use
___Anger
___Anxiety
___Assertiveness
___Athletic Performance
___ADHD
___Bipolar Disorder
___Body Image Distress
___Caretaking
___Clarification of Values
___Coming-out Process
___Confidence
___Decision Making
___Depression
___Difficulty Choosing
___Career/Job/Next Step
___Disordered Eating
___Ending a Relationship
___Financial Concerns
___Grief
___Identity/Cultural Concerns
___Injury Recovery/Rehab
___Interpersonal Problems
___Internet/Tech Addiction
___Life Transition
___Obsessions/Compulsions
___Parenting Problems
___Physical Medical Concern
___Relationship Problems
___Self-Acceptance/Esteem
___Self-Care
___Self-Understanding
___Sexual Health Issues
___Sexual Orientation Questions
___Sleep Problems
___Stress Management
___Substance Use
___Suicidal Thoughts
___Working Through Past Events

Other_____

How does this look for you? (select one or more)

___change in appetite or eating habits
___significant weight gain/loss
___change in mood
___irritability
___feelings of worthlessness
___changes in sleep
___loss of energy
___loss of interest in activities
___significant change in sexual interest
___lost or irregular menstrual cycle
___increase of energy
___difficulty concentrating
___nightmares
___increased substance use (alcohol, nicotine, drugs, caffeine)
___problems with attention, motivation, memory
___recurrent and excessive anxiety or worry
___feelings of restlessness
___trembling or shaking
___accelerated heart rate
___shortness of breath
___sweating
___chest pain
___feelings of choking
___nausea
___recurrent thoughts of death
___recurrent thoughts of wanting to commit suicide
___recurrent thoughts of harming others
___cutting, punching or burning myself
___seeing things that others do not
___hearing voices that others do not
___paranoid thoughts

Other_____

History of Presenting Concerns and Mental Health Treatment

Describe what brings you in for therapy: _____

_____

_____

_____

When did this become an issue? _____

_____

Have you ever had counseling for this concern in the past? (circle one) Yes No

If so, when and for how long? _____

What was the most helpful part of the care you received? _____

_____

Have you ever had counseling for another reason in the past? (circle one) Yes No

If so, when and for how long? _____

For what concern? _____

What was the most helpful part of the care you received? _____

_____

Have you ever been hospitalized for mental health treatment? (circle one) Yes No

Have you ever been admitted to residential or intensive outpatient services? (circle one) Yes No

Have you ever been prescribed a medication with psychological effects? (circle one) Yes No

If so, are you taking it now? (circle one) Yes No

What is it and how long have you taken it? _____

_____

If in the past, when, what was it, and for how long did you take it? _____

_____

_____

_____

_____

How have you coped with your presenting concern so far?

_____

_____

_____

What strengths do you bring to this problem which will assist you in overcoming it?

_____

_____

_____

Describe your support system (friends, family, spiritual or cultural groups, etc.) and are they nearby?

_____

_____

_____

Please describe your goals for therapy. What might be different if you were to achieve them?

_____

_____

_____

Is there anything else that you think is important for me to know about? If so, please describe:

_____

_____

_____

Acknowledgement

Please sign and date this document attesting that the information you have written throughout this form is accurate to the best of your knowledge.

_____ _____

Signature Date