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INTAKE QUESTIONNAIRE

GENERAL INFORMATION

NAME_____ TODAY'S DATE_____

WHAT SHOULD I CALL YOU? _____

ADDRESS_____

HOME/CELL PHONE#_____ALTERNATE PHONE#_____

EMAIL_____

PREFERRED CONTACT METHOD: _____

EMERGENCY CONTACT (name/phone #) _____

GENDER (circle one): [male] [female] [MtF] [FtM] [intersexed] [andro] [unsure] [decline]

SEXUAL ORIENTATION (circle one): ["I like boys/men only"] ["I like girls/women only"]
["I like both males and females"] ["I'm not sure who or what I like"] [decline]

DATE OF BIRTH_____ AGE_____

WHAT IS YOUR ETHNICITY? _____

IN WHAT CITY/STATE/COUNTRY WERE YOU BORN? _____

HIGHEST DEGREE COMPLETED & FROM WHERE _____

ARE YOU CURRENTLY A STUDENT? [yes] [no]

IF “YES”, WHERE & WHAT MAJOR? _____

PLACE OF EMPLOYMENT _____JOB TITLE _____

RELATIONSHIP STATUS (circle all that apply): [single] [dating someone] [dating a few people] [in a monogamous relationship] [in an open relationship] [widowed] [separated] [married/civil union/domestic partnership] [divorced]

ARE YOU CURRENTLY LIVING WITH SOMEONE YOU WERE FORMERLY IN AN INTIMATE

RELATIONSHIP WITH? [yes] [no] IF “YES”, PLEASE EXPLAIN: _____

_____

NAMES AND AGES OF ANY CHILDREN_____

_____

FINANCIAL INFORMATION

HOW MANY PEOPLE IN YOUR HOUSEHOLD (including yourself) _____

ANNUAL HOUSEHOLD INCOME_____ DO YOU [own] OR [rent]?

HOW DO YOU PLAN TO PAY FOR THERAPY? (circle all that apply): [check] [cash] [credit card]

I DO NOT CURRENYLY ACCEPT ANY INSURANCE PLANS, HOWEVER, IF YOUR INSURANCE CARRIER COVERS COUNSELING I WILL BE ABLE TO PROVIDE YOU WITH AN INVOICE--called a SuperBill—WITH WHICH YOU MAY POSSIBLY BE REIMBURSED (OR AT LEAST APPLY IT TO YOUR ANNUAL DEDUCTABLE). THIS INVOICE WILL BE MADE AVAILABLE, UPON REQUEST, AT OUR NEXT SCHEDULED MEETING

AREAS OF CONCERN

WHAT ISSUES & CONCERNS HAVE CAUSED YOU TO SEEK TREATMENT? _____

_____

_____

_____

DO YOU HAVE ANY SPECIFIC GOALS IN REGARDS TO YOUR TREATMENT? _____

_____

_____

_____

PLEASE DESCRIBE ANY PARTICULAR CONCERNS OR FEARS YOU HAVE IN REGARDS TO

THERAPY: _____

_____

_____

PSYCHOLOGICAL HISTORY

[REGARDING THE QUESTIONS IN THIS SECTION, NO THERAPIST WILL BE CONTACTED FOR RELEASE OF INFORMATION WITHOUT YOUR FORMAL WRITTEN AUTHORIZATION]

HAVE YOU PREVIOUSLY RECEIVED MENTAL HEALTH TREATMENT? [yes] [no]

IF "YES", WHEN AND FOR HOW LONG? _____

WHY WERE YOU SEEKING TREATMENT? _____

NAME OF THERAPIST(S) AND ADDRESS(ES), IF KNOWN:_____

_____

_____

HAVE YOU EVER BEEN ADMINISTERED A PSYCHOLOGICAL TEST? [yes] [no]

IF "YES", BY WHOM AND WHERE, IF KNOWN: _____

_____

HAVE YOU EVER BEEN HOSPITALIZED FOR A MENTAL OR EMOTIONAL CONDITION?

[yes] [no]

IF “YES”, WHEN AND FOR HOW LONG? _____

WHY WERE YOU HOSPITALIZED? _____

_____

NAME OF TREATING THERAPIST AND CONTACT INFORMATION, IF KNOWN: _____

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS FOR A MENTAL OR EMOTIONAL CONDITION? [yes] [no]

IF “YES”, WHICH MEDICATIONS AND HOW LONG HAVE YOU BEEN TAKING THEM? _____

_____

_____

WHO PRESCRIBED THESE MEDICATIONS? _____

IF YOU ARE NOT CURRENTLY TAKING THESE TYPES OF MEDICATIONS, BUT HAVE DONE SO IN THE PAST, WHEN WERE YOU TAKING THEM AND FOR HOW LONG?

_____

HAVE YOU EVER ATTEMPTED SUICIDE? [yes] [no]

IF “YES”, WHEN? _____

DESCRIBE THE CIRCUMSTANCES THAT LEAD TO THAT ATTEMPT: _____

_____

_____

ARE YOU CURRENTLY HAVING ANY SUICIDAL THOUGHTS? [yes] [no] [not sure]

IF “YES” OR “NOT SURE”, PLEASE DESCRIBE: _____

_____

_____

PLEASE DESCRIBE YOUR CHILDHOOD: _____

_____

WERE YOU EVER SUBJECTED TO VERBAL, EMOTIONAL, PHYSICAL, AND/OR SEXUAL ABUSE AS A CHILD? [yes] [no] [not sure]

IF “YES” OR “NOT SURE”, PLEASE DESCRIBE: _____

_____

_____

HAVE YOU EVER BEEN A VICTIM OF A VIOLENT CRIME? [yes] [no]

IF “YES”, PLEASE DESCRIBE: _____

_____

MEDICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH A SERIOUS ILLNESS? [yes] [no]

IF “YES”, PLEASE DESCRIBE: _____

_____

DO YOU HAVE ANY MEDICAL CONDITIONS THAT MAY EFFECT YOUR MENTAL HEALTH TREATMENT? [yes] [no]

PLEASE DESCRIBE YOUR OVERALL HEALTH TODAY: _____

_____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

ARE YOU EXPERIENCING ANY MEDICAL/PHYSICAL SYMPTOMS YOU ATTRIBUTE TO A MENTAL, EMOTIONAL, OR STRESS-RELATED CONDITION? [yes] [no] [not sure]

IF “YES” OR “MAYBE”, PLEASE DESCRIBE: _____

_____

BESIDES ANY MEDICATION FOR A MENTAL OR EMOTIONAL CONDITION, ARE YOU CURRENTLY TAKING ANY OTHER TYPE OF MEDICATION? [yes] [no]

IF “YES”, LIST EACH AND WHO PRESRIBED IT: _____

_____

_____

HAVE YOU EVER BEEN IN A 12-STEP PROGRAM? [yes] [no]

IF “YES”, WHICH ONE(S)? _____

DO YOU SMOKE? [yes] [no] HOW MUCH? _____ FOR HOW LONG? _____

DO YOU DRINK ALCOHOL? [yes] [no]

IF “YES”, HOW MUCH DO YOU CONSUME IN A WEEK? _____

DO YOU CURRENTLY USE ANY ILLEGAL DRUGS? [yes] [no]

IF “YES”, PLEASE DESCRIBE YOUR USE: _____

_____

IF NOT NOW, HAVE YOU EVER USED ILLEGAL DRUGS? [yes] [no]

IF “YES”, PLEASE DESCRIBE YOUR FORMER USE: _____

_____

FAMILY OF ORIGIN HISTORY

MOTHER’S NAME_____ [living] OR [deceased] AGE (if living)_____

IF DECEASED, YOUR AGE AT TIME OF DEATH_____

DESCRIBE YOUR RELATIONSHIP WITH HER _____

FATHER’S NAME_____ [living] OR [deceased] AGE (if living) _____

IF DECEASED, YOUR AGE AT TIME OF DEATH_____

DESCRIBE YOUR RELATIONSHIP WITH HIM _____

NAMES AND AGES OF ANY SIBLINGS: _____

_____

OTHER INFORMATION

PLEASE DESCRIBE YOUR SPIRITUAL IDENTITY/ORIENTATION: _____

_____

PLEASE DESCRIBE YOUR HOBBIES/INTERESTS: _____

_____

ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN A LAWSUIT? [yes] [no]

IF “YES”, PLEASE DESCRIBE: _____

_____

PLEASE FEEL FREE TO INCLUDE ANY OTHER INFORMATION THAT YOU BELIEVE IS RELEVANT TO YOUR MENTAL HEALTH TREATMENT, NOT PREVIOUSLY ASKED: _____

_____

_____