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Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. **Please note:** information provided on this form is protected as confidential information.

Personal Information

Date: _____

Name:_____

Address: _____

DOB: _____ Age: _____ Gender: _____ Pronouns: _____

HIPPA requires obtaining your written permission to contact you via mail, email, or phone.

May mail be sent to your address listed above? (ex: newsletter or business mail)? □ Yes □ No

Phone Numbers: H: _____ C: _____ W: _____

May we text you on your cell phone? _____ Yes _____ No
**Please note: text messages are not considered to be a confidential medium of communication.*

If we call, on which numbers may we leave a message? (circle) Home Cell Work None

Email: _____ May I email you? ____ Yes ____No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Emergency Contact Name: _____ phone: _____
I authorize contacting the above-named person in case of an emergency: ____ Yes ____No

How did you hear about us?/Referred by (if any):
_____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced, how long ago? _____ □ Widowed, how long ago? _____

Years together/married? _____

If married, is this your first marriage? □ Yes □ No List marriage(s) prior to this one: _____

_____

Where did you grow up? _____

Education: (last level completed) _____

Occupation: _____
Are you currently employed? □ Yes □ No Do you enjoy your work? Is there anything stressful about your current work? What do you find most satisfying about your work?

_____

What do you consider to be some of your strengths? _____
_____
_____

What do you consider to be some of your weaknesses? _____
_____
_____

What is one thing on your bucket list? _____

What do you feel are your life lessons that you have learned or are learning? _____
_____
_____

What do you feel is your life purpose? _____
_____
_____

What do you enjoy doing? (hobbies, outdoor activities, etc.) _____
_____
_____

History

Are your parents living? Father □ Yes □ No Year deceased? _____
Mother □ Yes □ No Year deceased? _____

Did your parents divorce? □ Yes □ No If your parents divorced, how old were you? _____

Do you have stepparents? Stepmother _____ Stepfather _____

Do you have children? □ Yes □ No

In space below list names and ages of children. (Designate which are your children, and which are stepchildren):

_____

_____

Do you have siblings? □ Yes □ No

List siblings, including yourself, from oldest to youngest, with current age:

_____

_____

_____

Any family history of abuse in your biological family? □ Yes □ No. What type of abuse? _____

Family Mental Health History

In the section below, identify if there is a **family** history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Members
Alcohol/Substance Abuse	Yes/No	_____
Anxiety	Yes/No	_____
Depression	Yes/No	_____
Bipolar/Manic Disorders	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obesity	Yes/No	_____
Obsessive Compulsive Behavior	Yes/No	_____
Schizophrenia	Yes/No	_____
Suicide Attempts	Yes/No	_____

Anything else you'd like me to know about your family? _____

General and Mental Health Information

Do you have a meditation or spiritual practice? □ Yes □ No

If yes, what form of meditation or spiritual practice? _____

How often do you meditate or practice? _____

How do you find it of benefit? _____

What challenges do you experience with your practice? _____

Do you have a spiritual mentor/guide/teacher/church or organization? □ Yes □ No. If yes, please list:

_____

_____

Have you previously or currently receiving any type of alternative health treatment? Check all that apply:

□ Chiropractic practitioner's name: _____
□ Acupuncture practitioner's name: _____
□ Energy/spiritual healing (Reiki, Healing Touch, Theta Healing, etc.) Practitioner's name:
_____
□ Biofeedback/Neurofeedback Practitioner's name: _____
□ Reflexology Practitioner's name: _____
□ Massage Practitioner's name: _____
□ Herbalist Practitioner's name: _____
□ Ayurvedic Medicine/diet Practitioner's name: _____
□ Yoga Therapy/yoga practice Practitioner's name: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No, previous therapist/practitioner: _____

Are you currently taking any prescription medications, vitamins, herbal remedies? If so, please list what they are, and what they're for:

_____
_____
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No. If yes, please list and provide dates:

_____
_____

Have you been hospitalized in the last 3 years? □ Yes □ No If so, for what?

_____
_____

Have **you** been diagnosed with or experienced any of the following in the past or currently?

Alcohol/Substance Abuse Yes/No _____
Anxiety Yes/No _____

Depression	Yes/No	_____
Bipolar/Manic Disorders	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obesity	Yes/No	_____
Obsessive Compulsive Behavior	Yes/No	_____
Schizophrenia	Yes/No	_____
Suicide Attempts	Yes/No	_____
Currently having suicidal thoughts	Yes/No	_____

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____
_____

Any syndrome, disease, condition, or illness? □ Yes □ No If yes, what?
_____
_____

Do you have, or have you had, any of the following: (For each issue checked "yes" below, give details on frequency and severity.)

		Details, frequency, severity
Migraines/headaches	□ Yes □ No	_____
Stomach problems	□ Yes □ No	_____
Thyroid issues	□ Yes □ No	
Cancer	□ Yes □ No	_____
Heart Disease	□ Yes □ No	_____
Diabetes	□ Yes □ No	_____
Carpel tunnel	□ Yes □ No	
Numbness, tingling	□ Yes □ No	_____
Feeling spacey or "out of body"	□ Yes □ No	_____
Extreme fatigue	□ Yes □ No	_____
Exhausted/tired/little energy	□ Yes □ No	_____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

How many hours a night do you sleep? _____ Is that amount of sleep usual for you? □ Yes □ No

Please list any specific sleep problems you are currently experiencing:
_____
_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems: _____
_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long?_____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: _____

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ None

What significant life changes or stressful events have you experienced in the last 3 years? (ex: separation, divorce, death of a family member, loss of a job, major illness, moving, etc.)
_____
_____

Answer the following statements:

"I have lost interest in many things I once enjoyed doing."	□ Yes □ No
"I have racing thoughts and find it difficult to concentrate."	□ Yes □ No
"I feel afraid much of the time."	□ Yes □ No
"I have plenty of energy."	□ Yes □ No

If you checked yes to any of the above statements, are these symptoms recent or been going on for a long time? How long? _____

Dreams & Aspirations

What would you **love** to **<u>do or have</u>** in the following areas?
Health & Wellbeing _____
Relationships _____
Vocation (Job/Career) _____
Time & Money Freedom _____

How would you **love** to **<u>be</u>** in the following areas?
Health & Wellbeing _____
Relationships _____
Vocation (Job/Career) _____
Time & Money Freedom _____

Current reasons for seeking counseling
Why did you make the effort to call a professional counselor?

_____
_____
_____
_____

What is your intention for therapy? What would you like to see happen or accomplish?

_____
_____
_____
_____

The thing that concerns me the most now is?

_____
_____
_____
_____

Is there anything else you think it important for the counselor to know right now?

_____
_____
_____
_____

What do you want most to talk about in today's session?

_____
_____
_____
_____

POLICY

A counseling session is normally 60 minutes long. Payment is expected at the beginning of each session. If you cannot make it to an appointment, 24-hours notice is required. If appointments are made, and 24-hour notice is not given, the usual fee will apply, even for clients with Blue Cross Blue Shield and Ambetter insurance.

The therapist requires that credit card information be kept on file in case a no-show charge is applied. Refusal may result in cancellation of appointment by the therapist. **THE CREDIT CARD INFORMATION GOES ON THE THERAPEUTIC INFORMED CONSENT FORM. Please be sure to read and sign the Therapeutic Informed Consent form, which states that you understand and agree to the policies of this therapist.**

The therapist will maintain strict confidentiality. However, I understand that suicidal threats, homicidal threats, child or elder abuse will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

I understand that I have the right to refuse treatment at any time.

Counselor Signature: _____Date: _____

Client Signature: _____Date:_____