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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.

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:__________________