Intake Information
(to be completed by client and/or legal guardian)

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for treatment.

Name: _____ Date of Birth: _____

Address: _____

Telephone number Home: _____ Work: _____

Can I leave a message at home? ☐ Yes ☐ No Can I leave a message at work? ☐ Yes ☐ No

Can you be reached by Email? ☐ Yes ☐ No Email address: _____

Occupation: _____ Employer: _____

Highest level of education: _____

How satisfied are you with your job? _____

Briefly describe your reason(s) for seeking help at this time: _____

_____

What do you wish to accomplish through the process of therapy? _____

_____

Marital/Relationship Status (check all that apply):

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Remarried

☐ Single ☐ Long term relationship ☐ Cohabitating

Other: _____

Current partner's name: _____ Occupation: _____

Length of relationship: _____ How satisfied are you with this relationship? _____

Do you have any children (biological, adopted, foster, step, etc.)? ☐ Yes ☐ No

If yes, please list names and ages:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Do your children currently live with you? ☐ Yes ☐ No

If no, where do they live? _____

How often do you see them? _____

Have you ever been in therapy before? ☐ Yes ☐ No

If yes, briefly describe the reason(s), date(s), and length of treatment: _____

_____

Was it a positive experience? ☐ Yes ☐ No

What did you like/not like about it? _____

Basic Health?: ☐ Good ☐ Fair ☐ Poor

When was your last physical exam? _____

Who is your Physician? _____

Do you have any difficulty sleeping? ☐ Yes ☐ No

If yes, please describe briefly: _____

Do you have any chronic illnesses, medical conditions, or injuries? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever had any head injuries or concussions? □ Yes □ No

Are you presently taking any medication? ☐ Yes ☐ No

If yes, please list: _____

Are you taking any over the counter medications, herbs, supplements, etc.? ☐ Yes ☐ No

If yes, what? _____

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of?

☐ Yes ☐ No If yes, what?: _____

Have you ever been hospitalized? ☐ Yes ☐ No

If so, for what?: _____

What do you enjoy doing in your spare time? _____

Are there things that you used to do, or would like to do, but currently don't? _____

How would you describe your spiritual or religious beliefs?_____

Is there anything else you think would be important for me to know about you or your family or family history?

_____

_____

Did someone refer you? ☐ Yes ☐ No

If yes, who? _____

May I contact him or her? ☐ Yes ☐ No

Please circle any of the following that presently cause you difficulty:

Assertiveness	Parenting	Digestive issues	Nightmares
Bedwetting	Nervousness	Physical abuse	Education
Temper	Stress	Memory	Headaches
Unhappiness	Premarital	In-laws	Health problems
Alcohol use	Sexual problems	Loneliness	Ulcers
Energy	Children	Divorce	Depression
Inferiority	Drug use	Finances	Fears
Food	My past	Career choices	Legal matters
Marriage	Concentration	My thoughts	Sleep
Parents	Relaxation	Sexual abuse	Friends
Sadness	Appetite	Work	Self-control
Guilt	Stomach problems	Self-concept	Religion
Separation	Suicidal thoughts	Decision making	Insomnia
Ambition	Shyness	Dating	Fatigue
School	Confusion	Past Trauma	

Other: _____

Now put an * by the items that are causing you the MOST difficulty.