Client Questionnaire/Intake

General:

Name _____ Date _____

Address _____ Home phone _____

Work phone _____ Fax _____

E-mail _____ Referred by _____

Age _____ Date of birth _____

Marital status _____ Educational level _____

Occupation _____

Names and ages of children _____

_____

Emergency contact information _____

How can I contact you? _____

Are messages okay? Yes_____ No_____

Financial Information:

Annual household income _____ Do you own or rent? _____

How do you intend to pay for treatment? (cash, check) _____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____

_____

_____

_____

Do you have any specific goals with regard to your treatment?_____

_____

_____

_____

Do you have any particular concerns/fears with regard to treatment? _____

_____

_____

_____

Psychological History

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Name of treating therapist(s), address(es), telephone number(s) _____

_____

Are you willing to sign a release so that your current therapist may discuss your situation and history with any former therapists? Yes_____No_____N/A_____

Have you ever been subjected to one or more psychological tests? _____

If so, by whom? _____

Name of person(s) administered psychological tests, address(es), telephone number(s)

_____

_____

Are you willing to sign a release so that your current therapist may discuss test findings with test administrator? Yes_____No_____N/A_____

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long? _____

Why were you hospitalized? _____

Name of treating therapist, address, telephone number _____

Prescription medications				
Use the chart below to list **all** the brand-name and generic prescription medications you currently take. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the prescription label in milligrams (mg). This is called the dose, or strength. The label on liquids and shots lists the dose too.				
Medication name	**Prescribing doctor's name**	**Reason for taking the medication**	**Dose (such as 2 mg, 1 tsp)**	**How often? (such as 3x/day)**

Nonprescription medications, vitamins, and supplements			
List all those you take occasionally, such as aspirin for headache, as well as those you take every day, such as a multivitamin or nutritional supplement. Include any herbs or alternative medicines that you take.			
Name	**Reason for taking the medication**	**Dose**	**How often? (such as 3x/day)**

Are you willing to sign a release so that your current therapist may discuss your situation and history with any health care provider? Yes_____No_____N/A_____

Have you ever attempted suicide? _____

When? _____

Describe the circumstances that led to that attempt. _____

_____

_____

Are you currently having any suicidal thoughts? Please describe _____

_____

_____

Do you have any access to guns?_____

_____

Please describe your childhood .

_____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

_____

_____

_____

Have you ever been a victim of a violent crime? Please describe _____

_____

_____

Medical History

Have you ever been diagnosed with a serious illness? Please describe_____

_____

_____

Do you have any medical conditions that may affect your mental health treatment? ____

_____

Please describe your overall health today. _____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

_____

_____

Have you ever been in a 12-step program? Please describe. _____

_____

_____

Do you smoke? _____ How much? _____ For how long? _____

On average, how much alcohol do you consume in a week?_____

Do you currently use illegal drugs? Please describe your use _____

_____

Have you ever used illegal drugs? Please describe. _____

_____

Family of Origin History

Mother's name, age, living/deceased, client's age at the time of mother's death, description of relationship with mother. _____

_____

_____

_____

_____

Father's name, age, living/deceased, client's age at the time of father's death, description of relationship with father. _____

_____

_____

_____

_____

Names and ages of siblings. _____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe. _____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____

_____

_____

_____