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: ____

Home Phone: ______________________________ Can I leave a message? ☐ Yes ☐ No

Work Phone: ______________________________ Can I leave a message? ☐ Yes ☐ No

Email Address: ______________________________ Can I send you emails? ☐ Yes ☐ No

Level of Education ☐ High School ☐ Associate ☐ Bachelor's ☐ Master's ☐ Doctorate

Occupation: ____________________ Employer: ____________________

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 ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed

☐ Single ☐ Cohabitating ☐ Long Term Relationship ☐ Other ______________

Current partner's name: ____________________ Occupation: ____________________

Length of relationship: __________ How satisfied are you with this relationship? ______________

Do you have any children (biological, adopted, foster, etc.)? If so, please list their names and ages. ☐ Yes ☐ No

Name: ____________________ Age: ______

Name: ____________________ Age: ______

Name: ____________________ Age: ______

Do your children currently live with you?	☐ Yes ☐ No	If no, where do they live? ____________________ ____________________ ____________________
Have you ever been in therapy before?	☐ Yes ☐ No	If yes, describe the reason(s), date(s), and length of treatment: ____________________ ____________________
Was it a positive experience?	☐ Yes ☐ No	
How is your 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 briefly: ____________________ ____________________
Have you ever had any head injuries or concussions?	☐ Yes ☐ No	If yes, please describe briefly: ____________________ ____________________
Are you presently taking any medications, herbs, supplements, etc.?	☐ Yes ☐ No	If yes, please describe briefly: ____________________ ____________________
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, please describe briefly: ____________________ ____________________ ____________________
Have you ever been hospitalized?	☐ Yes ☐ No	If yes, please describe briefly: ____________________ ____________________

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?	☐ Yes ☐ No	If yes, please describe briefly: ____________________ ____________________

How would you describe your spiritual or religious beliefs?____________________

Please describe anything else you think would be important for me to know about you, your family or family history.

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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	Grief	In-laws
Health problems	Alcohol use	Sexual problems	Loneliness	Ulcers
Energy	Children	Divorce / Separation	Depression	Inferiority
Drug use	Finances	Fears	Past Trauma	My past
Career choices	Legal matters	Marriage	Concentration	My thoughts
Sleep	Parents	Relaxation	Sexual abuse	Friends
Sadness	Appetite	Work	Self-control	Guilt
Confusion	Self-concept	Religion	School	Suicidal thoughts
Decision making	Insomnia	Ambition	Shyness	Dating
Fatigue				

Others: ____

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