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INTAKE QUESTIONNAIRE

Part I

Today's Date:_____

A. IDENTIFICATION:

Name:_____
Date of Birth:_____ Age:_____
Email Address:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Cell:_____ Home phone:_____

Please describe the events/incident that led you to seek therapy and what you hope to gain from participating in counseling:

_____

_____

_____

B. REFERRAL:

Who gave you my name to call? _____

C. EDUCATION AND TRAINING:

Dates

From	To	School	Degree/focus of study	Did you graduate
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

D. EMPLOYMENT AND MILITARY EXPERIENCES:

Dates

From	To	Name of military or Employers	Job title or duties
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

E. FAMILY OF ORIGIN HISTORY:

Please list ages of your birth/adoptive parents, and the number of siblings you have and their ages:

If they are no longer living please write “deceased”

Father:_____ Mother:_____

Other Caregivers/Guardians:_____

Brothers: #____ Name/Ages:_____

Sisters: #_____ Names/Ages:_____

F. MARITAL/RELATIONSHIP HISTORY:

Please list your significant marital/domestic partners beginning with your most recent marriage.

	Spouses Name/Age at marriage	Your Age at at marriage	Your Age when divorced/widowed	Is spouse remarried?
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

G. OTHER SIGNIFICANT NON-MARITAL RELATIONSHIPS:

Please provide information about your other significant romantic relationships outside of marriage. Please begin with the most current.

	Name of Significant other	Length of relationship	Reason for break-up
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

H. CHILDREN:

P**lease list your children. Check if you have physical custody/they are presently live with you.**

1. Full name:_____ Age:____ Sex: Male/Female
   Custody/Visitation_____
2. Full name:_____ Age:____ Sex: Male/Female
   Custody/Visitation_____
3. Full name:_____ Age:____ Sex: Male/Female
   Custody/Visitation_____
4. Full name:_____ Age:____ Sex: Male/Female
   Custody/Visitation_____
5. Full name:_____ Age:____ Sex: Male/Female
   Custody/Visitation_____

Part II

CLINICAL HISTORY

I. TREATMENT HISTORY:

Please list prior mental health treatment including counseling, psychological and psychiatric.

When	Provider	For What?	Results/Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list medications you have been prescribed for emotional, mental health symptoms.

When	Medication	Provider	For What Symptom	Results
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been treated at a psychiatric hospital?_____ # of times:_____

Have you ever attempted suicide?_____ # of times:_____ Have you engaged in any type of self-injurious behavior?_____ Describe:_____

J. RELATIONS IN YOUR FAMILY OF ORIGIN:

Please describe the following:

1. Your parents' relationships with each other:_____
_____

2. Your relationship with each parent and other significant adults in your life:_____
_____
_____
_____

3. Your parents' physical health problems, substance use, and mental/emotional difficulties:
_____
_____
_____
_____

4. Your relationship with your brothers and sisters, in the past and present: _____
_____
_____

_____

5. Are there other members of your family who have mental health, emotional, and/or substance abuse difficulties?_____
_____
_____

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K. ABUSE AND TRAUMA HISTORY:

I was abused/mistreated: Yes_____ No:_____

If you were abused, please indicate the type of abuse by using the letters: **P=Physical** (such as beatings), **S=Sexual** (such as touching,molesting, fondling or intercourse), **E=Emotional** (such as humiliation, name calling, and shaming), **N=Neglect** (such as failure to feed, shelter,or protect you).

Type	Age of Abuse	By Whom
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional traumatic incidents:_____
_____
_____
_____

L. RECREATION:

How many times a week do you see or spend time with friends?_____ What do you enjoy doing in your free time?_____
_____

Do you participate in any clubs, organizations, sports, or special interest groups?_____
_____

M. SUBSTANCE USE, GAMBLING, and IMPULSE CONTROL:

1. Have you ever felt the need to cut down on your drinking (alcohol)? Yes____ No____
2. Have you ever felt the need to cut down on your drug use? Yes____ No____
3. Have you ever felt the need to cut down on your smoking/vaping? Yes____ No____
4. Have you ever felt the need to cut down on your gambling? Yes____ No____
5. Do you have any other impulsive behavior you are concerned about? Yes____ No____

If you answered “yes” to any of the above, please describe:_____
_____
_____
_____

Amount of alcoholic drinks you consume on average:_____ Caffeine drinks:_____
List substances you have used:_____
_____
_____

Has your gambling effected your ability to meet financial obligations?_____
Have other people complained about your gambling habits?_____ Who?_____

Have other people expressed concern about your substance use or impulsive behavior?_____

N. LEGAL HISTORY:

Have you ever been involved with Child Protective Services?_____ Describe:_____
_____

Are you required, by court, the police, or a probation/parole officer to have this appointment?_____
List all contacts with police, jail, incarceration, courts including all open, closed and pending:

Date	Charge	Sentence	City/County/State/Federal Jurisdiction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parole/Probation Officer's Name:_____

Please Describe any current legal matters:_____
_____
_____

Your current Attorney's name:_____

O. Other:

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: _____