Sunlight Counseling LLC

Intake Questionnaire

Thank you for completing this form and any others that you are given by Sunlight Counseling LLC. The information you provide is confidential as outlined in *Sunlight Counseling LLC* Disclosure Statement and will help your therapist create a treatment plan tailored to meet your needs and those of your family.

Date: _______/________/_________
Month Day Year

Client Name:____ Date of Birth:____________ Age:__________

Gender: ☐ Male ☐ Female Social Security #____________________ Email:__________________________

Is Client a minor? ☐ Yes ☐ No If yes—Name of Parent/Guardian_______________________________________

Contact Information

Client (Parent/Guardian) Address: ____

____

May we leave a message?

Telephone: (Home)____________________ ☐ Yes ☐ No

(Cell)____________________ ☐ Yes ☐ No

(Work)____________________ ☐ Yes ☐ No

Emergency Contact: Please provide a name of person to contact in case of emergency.

Name____________________________ Relationship to client_________________________

Address: __________________________________ Telephone #1_____________________

__________________________________ Alternate telephone________________

Relationship Status (Check one)

☐ Single ☐ Engaged ☐ Cohabitating ☐ Significant Other

☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If married

Is this your first marriage? ☐ Yes ☐ No

If yes—How long have you been married?______________________

If no—How many times have you been married before your current marriage?______________

How many years have you been married to your current spouse?_________________

Have you and your current spouse ever separated ? ☐ Yes ☐ No

If yes—When did you and your spouse separate? ____

For how long were you separated?____

If Divorced—How long have you been divorced?____

If Widowed—How long have you been widowed?____

Children

Do you have children? ☐ Yes ☐ No

If yes, Please complete the following:

Name	Date of birth	Living with you	Gender
First_______________________________________	_______________	☐ Yes ☐ No	☐ M ☐ F
Second_____________________________________	_______________	☐ Yes ☐ No	☐ M ☐ F
Third______________________________________	_______________	☐ Yes ☐ No	☐ M ☐ F
Fourth_____________________________________	_______________	☐ Yes ☐ No	☐ M ☐ F
Fifth______________________________________	_______________	☐ Yes ☐ No	☐ M ☐ F

Are there presently any child custody issues involving you or your family? ☐ Yes ☐ No

Does your family currently have Child Protective Services involved? ☐ Yes ☐ No

If yes—Please complete the following: Case worker's name____

Phone#_______________________State____________________County__________________________

Educational Level

	Attended some	Currently attending	Completed
☐ Child – Not in school			
High School	☐	☐	☐
Technical School	☐	☐	☐
College: Associates Degree	☐	☐	☐
College: Bachelors Degree	☐	☐	☐
Graduate Degree (Masters)	☐	☐	☐
Graduate Degree (Doctoral)	☐	☐	☐

Employment (Check one)

☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Unemployed

☐ Homemaker ☐ Other, (Please specify)____

Insurance Information:

Will you be using insurance to pay for your sessions? (Applicable co-pays will still apply) ☐ Yes ☐ No

If yes, please provide your insurance card for photocopying.

Primary insurance____

Secondary insurance_______________________________________

Referral Source:

Were you referred to our office? ☐ Yes ☐ No If yes—by whom?______________________________________

If no—How did you hear or learn about our office?____

Medical/Psychological History

Who is providing client's history information? ☐ Client ☐ Parent/Guardian ☐ Other________________________

Please describe the current complaint or problem as specifically as you can in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Please check all words/phrases that express what you are experiencing and explain if possible.

☐ Substance abuse/dependence	☐ Anxious/nervous/tense feelings
☐ Addiction (Internet, Pornography, shopping, exercise, gaming, gambling, etc)	☐ Panic attacks
☐ Depression/Sad/Down feelings	☐ Racing or scrambled thoughts
☐ High/Low energy level	☐ Nightmares/Flashbacks
☐ Angry/Irritable	☐ Hearing voices/hallucinations
☐ Loss of interest in activities	☐ Thoughts of running away
☐ Difficulty enjoying things	☐ Paranoid thoughts
☐ Crying spells	☐ Feelings of being cheated
☐ Decreased motivation	☐ Perfectionism
☐ Withdrawing from people/isolation	☐ Rituals of counting things; washing hands; checking locks, doors, stove; etc/Overly concerned about germs
☐ Mood swings	☐ Dissatisfaction with body image
☐ Change in weight or appetite	☐ Concerns about dieting
☐ Change in sleeping patterns	☐ Feelings of loss of control regarding eating
☐ Suicidal thoughts or plans/thoughts of hurting yourself	☐ Binge eating/Purging
☐ Self Harm (Cutting, burning etc)	☐ Excessive exercise
☐ Homicidal thoughts or plans/ thoughts of hurting others	☐ Rules about eating
☐ Poor concentration/difficulty focusing	☐ Indecisiveness about career
☐ Feelings of hopelessness/worthlessness	☐ Job problems
☐ Feelings of shame or guilt	☐ Other_______________________________________
☐ Feelings of inadequacy/low self-esteem	

Have you received or participated in previous counseling or therapy? ☐ Yes ☐ No

If yes—Who was your therapist?____

When did you begin therapy with them and for how long?____

Have you ever been hospitalized for psychological concerns? ☐ Yes ☐ No

If yes—briefly explain:

List current medications:

Major current health concerns:

Have you ever experienced any significant head injuries? ☐ Yes ☐ No

Explain any allergies:

Do you have a primary care physician? ☐ Yes ☐ No

If yes—Please provide name___________________________________Group_______________________________

Address:_____________________________________

____

Telephone:_______________________________________

What goals/expectations do you have for counseling therapy?

Is there any additional information that you believe is important for your therapist to know? Please explain.

____ _________________________________

Client Signature (Parent or Guardian if minor) Date