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Therapy for Individuals and Couples

Questionnaire/Intake Form

General:

Name _____ Date _____
Address _____ 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 _____
Explanation of how patient may be contacted by therapist _____

Financial Information:

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

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) _____

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)

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: _____

Are you currently taking any prescription medications? _____

Prescribed by whom?

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long?

Have you ever attempted suicide? _____

When? _____

Describe the circumstances that led to that attempt.

Are you currently having any suicidal thoughts? Please describe

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 cigarettes? _____ How much? _____ For how long?

Do you drink alcohol? _____

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

Do you currently any other substances? Please describe your use (marijuana, cocaine/crack, meth, hallucinogens, opiates, etc) _____

Have you ever attended residential treatment for substance use issues? Please describe where and when:

Family of Origin History

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

Father's name, age, living/deceased, patient'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.