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 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___________________________

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____

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 /Siblings (If client is a child please list client's siblings. If client is an adult, list client's children.)

Adult: Do you have children? ☐ Yes ☐ No Child: Does your child have siblings? ☐ Yes ☐ No

If yes, Please complete the following:

Name	Date of birth	Age	Living with you	Name of other parent
First____	_______________	___	☐ Yes ☐ No	_______________
Second____	_______________	___	☐ Yes ☐ No	_______________
Third____	_______________	____	☐ Yes ☐ No	_______________
Fourth____	_______________	____	☐ Yes ☐ No	_______________
Fifth____	_______________	____	☐ Yes ☐ No	_______________

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___________________________

Education of Client:

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

Employment of client (Check one)

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

☐ Homemaker ☐ Other, (Please specify)____

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?

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

☐ Substance abuse/dependence –If so, what is/are you drug/drugs of choice?	☐ 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) -Date of last experience:	☐ 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 known diagnosis:

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.

I agree to receive (or agree that the client named above may receive) therapy at Sunlight Counseling LLC and I acknowledge that I have received, read, understand and agree to the terms outlined in the **Professional Disclosure** of Sunlight Counseling LLC. I also acknowledge that I have received or have been offered a copy of the **Notices of Privacy Practices** of Sunlight Counseling LLC and that I understand the contents thereof.

____

PRINT CLIENT'S NAME

____ ____________________

Signature of client or legal representative Date

____ ______________________________

Client Signature (Parent or Guardian if minor) Date