Client Intake Questionnaire

Prior to the commencement of treatment, the therapist would like to have the client complete a comprehensive intake questionnaire. The information provided will be helpful to the therapist in several ways, including, but not limited to, understanding the client's chief complaints, knowing how the client would prefer to be contacted, and understanding the client's mental health and medical treatment history. Acquiring this information is a critical component of an overall intake process and goes hand-in-hand with informed consent. In the same way that each client needs information from the therapist to determine whether the therapist is the right fit for themselves; the therapist is proactive in gathering enough information about the client to determine whether they are an appropriate fit for the therapist.

General:

Name ________________________________ Date_________________________

Address ______________________________ Home phone __________________

Work phone __________________ Cell phone ____________________

Email ______________________________ Referred by ____________________

Age ________________________________ Date of birth ___________________

Marital status _________________________ Educational level _______________

Occupation __________________________ Names and ages of children_______

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Emergency contact information ____

Explanation of how client may be contacted by therapist __________________________

_____ by phone _____ by email _____ by mail

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _________________

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Do you have any specific goals with regard to your treatment?______________________

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Do you have any particular concerns/fears with regard to treatment? _________________

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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) _____________________

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[Authorization for release of confidential information forms will be needed so that any former therapists may be contacted.]

Have you ever completed psychological testing? _________________________________

If so, by whom? ____

Name of person(s) administered psychological tests, address(es), telephone number(s)

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[Authorization for release of confidential information forms will be needed so that any former therapists may be contacted.]

Have you ever been hospitalized for mental or emotional reasons? _________________

When and for how long? ____

Why were you hospitalized? ____

Name of treating therapist, address, telephone number _____________________________

[Authorization for release of confidential information forms will be needed so that any former therapists may be contacted.]

Are you currently taking any prescription medications? ________________________________

Prescribed by whom? ____

How long have you been taking the medication?_______________________________________

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

When and for how long? ____

[Authorization for release of confidential information forms will be needed so that any former therapists may be contacted.]

Have you ever attempted suicide? ____

When? ____

Describe the circumstances that led to the attempt __________________________________

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Are you currently having any suicidal thoughts? Please describe _______________________

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Please describe your childhood ____

Were you ever subjected to verbal, physical, emotional, or sexual abuse? Please describe.

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Have you ever been a victim of a violent crime? Please describe _______________________

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Medical History

Have you ever been diagnosed with a serious illness? Please describe__________+_________

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Do you have any medical conditions that may affect your mental health treatment?

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Please describe your overall health today. ____

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Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. ____

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Have you ever been in a 12-step program? Please describe ________________________

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Do you smoke? _____ How much? ____________ For how long? _________________
Do you drink alcohol? _____________
On average, how much alcohol do you consume in a week?_______________________
Do you currently use any other drugs? Please describe your use_____________________
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Have you ever used any other drugs? Please describe.

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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 ______________________________________

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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.

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