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Client Questionnaire/Intake

Date Completed _____

Client or Parent's Name_____ Birth Date_____

If seeking counseling for child, Child's Name _____ Birth Date _____

Address _____City_____Zip_____

Cell (___)_____ Home (___)_____ Work (___)_____ Child's cell (___) _____

Please put a check next to the phone that is best to use. Is it OK to leave a message? Circle Y or N

Email _____ Referred by _____

Occupation _____ Employer _____ Educational Level _____

Marital Status _____ Name of Partner/Spouse _____

If seeking counseling for child and parents are divorced, who has **legal** custody? _____

Emergency contact info (name, contact & relationship) _____

Names and ages of children (or child's siblings): _____

_____ _____

_____ _____

Financial Information: *(if seeking a reduced fee)*

Annual gross household income (including partner/spouse income) _____

Number of people this income is supporting: _____

Medical Insurance: _____ Is counseling covered? _____

Legal History:

Are you now or have you ever been involved in a lawsuit? _____ If so, please describe:

_____

Please answer the following regarding the person seeking counseling.

Areas of Concern:

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

_____

Do you have any specific goals with regard to treatment?_____

_____

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

_____

Psychological History:

Have you ever talked to a counselor or therapist before? (circle one) Yes or No

When and for how long? _____

What was the focus of treatment? _____

Name of treating therapist(s) _____

Medical History:

Prescription medications that you currently take: _____

Who is your prescribing physician(s)?_____

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

When and for how long? _____

Have you ever been diagnosed with a serious illness? Please describe_____

_____

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. _____

_____

Who is your primary care physician? _____

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol or use recreational drugs? _____ What age did you start? _____

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

On average, how many days per week do you use recreational drugs? _____

Diversity History:

Please describe your spiritual identity/orientation and/or religious affiliation._____

_____ _____

Please describe your ethnicity and/or culture _____

Please describe your interests/hobbies _____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____

_____

_____