Intake Today's date:_____

This questionnaire will help your therapist understand your situation. If you feel uncomfortable answering any of the questions, you may leave them blank and discuss them when you meet with your therapist.

Name:_____
First Middle Initial Last

Home Address:_____
Street Address City State Zip Code

Phone: (Home) _____ (Cell) _____
(Ok to text circle Y or N)

Please circle preferred method of contact (home or cell)

Emergency Contact:
(Name)_____

(Phone) _____ (Relationship) _____

Insurance Information:
Primary Insurance:_____ Copay: _____

Member ID: _____

Secondary Insurance:_____ Copay: _____

Member ID: _____

Referred By: _____

Personal Information:
1. Age: _____ 2. Date of birth: _____ 3. SSN: _____

4. Gender _____

5. Ethnicity (circle all that apply):
Caucasian Black/African-American Asian
Hispanic Native American Other: _____

6. Religious background (circle one)
Protestant Catholic Jewish No affiliation Other: _____

7. Marital status (circle one):
Single (never married) Married Divorced Widowed Cohabiting Separated

8.Names of persons living in your home and your relationship to them.

Name	Gender (M/F)	Age	Relationship

Family/Social History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father,grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Neurological condition	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Panic attacks	yes/no	_____
Phobias	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

Education and Employment History

1. Are you going to school now? Yes/No (circle one) Full-time/Part-time (circle one)
If yes, what are you studying?

_____

2. Are you working toward a degree? Yes No (circle one) If yes, what degree?

_____

3. Highest level of education completed _____

4. Are you currently employed? Yes/No (circle one)
If yes, what is your current employment situation:

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5. Do you enjoy your work? Is there anything stressful about your current work?

_____

Current Problems and Treatment History

1. Please describe briefly the problem(s) that bring you in to see a therapist.

_____

_____

_____

a. When did you start having these problems? _____
b. Have you ever had problems like this before? Yes/No (circle one)
c. If yes,when_____

_____

2. Are you currently seeing another therapist/psychiatrist? Yes/No (circle one)
If yes, please provide the following information:
Therapist's name _____ Date treatment began_____

_____
Street Address City State Zip Code

3. Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy? Yes/No (circle one)
If yes, please provide the following information:

a) Has a health professional ever recommended hospitalization for mental or emotional difficulties or for drug or alcohol abuse? Yes No (circle one)

b) Have you ever been hospitalized in an inpatient program for mental or emotional difficulties or for drug or alcohol abuse? Yes No (circle one)

If yes, please complete the following:

Date hospitalized	Name of facility	Length of stay	Reason for hospitalization	Was it voluntary (Y/N)

4. Do you currently take medications to treat mental/emotional difficulties or substance abuse prescribed by a physician/psychiatrist? Yes No (circle one) If yes, please complete the following chart.

Medication	Dosage	Frequency	Name of Prescriber	Prescribed for what symptoms

5. Are you currently involved in any other activities to help with your symptoms? If yes, please describe._____
_____
6. Do you currently take any herbal supplements or medicines? Yes No (circle one)
If yes, what do you take? _____
_____
7. Have you ever made a suicide attempt? Yes No (circle one)
If yes, what method/substance did you use? _____
_____
8. Have you ever purposely harmed yourself (cutting, burning, or other)? Yes No

Medical History:

1. Do you now have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities? Yes/No If yes, please describe:

_____

_____

_____

2. Is this problem past or current? Past/Current
3. When was your last physical examination by a physician? _____
4. Who is your primary care physician (provide name address and phone#)?

_____

_____

Other Background:

1. Have you ever been involved in a lawsuit? Yes/No
If yes, please describe the circumstances and give dates:

_____

_____

_____

2. Have you ever been arrested? Yes/No
If yes, please describe the circumstances and give dates:

_____

_____

_____

3. Have you experienced any particular sources of stress in the last year? Yes/No
If yes, please explain:

_____

_____

_____

4. Are there any other health care professionals (e.g. physicians, psychotherapists) who have information that might help in your treatment? Yes/No

If yes, please provide that person's name and contact information:

_____

_____

_____

5. Is there any other information that would be helpful for me to know? Yes/No
If yes, please explain:

_____

_____

_____