

Intake Questionnaire

Date:
Name:
Address:
City, State, Zip:
Cell Phone: Home Phone:
Which number can I leave a message on? Home Phone Cell Phone Either

Who referred you?
My I contact them to thank them for the referral? Yes No

What issues do you want to address in therapy?

Have you been in therapy before? Yes No
Name of Clinician:
Dates:
Presenting Issue(s) you worked on with them:

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Have you addressed the issues you are coming here for in therapy before?	Yes	No
If yes, what were the results?		

Are you currently on any medications?	Yes	No
If yes, list all medications, dosages, and times of day you take them.		
Medication:		
Dosage:		
Times a Day:		
Who prescribed this medication?	Phone #:	

Medication:
Dosage:
Times a Day:
Who prescribed this medication? Phone #:
Medication:
Dosage:
Times a Day:
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Are you on any herbs, homeopathy, vitamins, etc.?	Yes	No
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If yes, please list below what you take, dosage and times a day.

Herb, Homeopathic, Vitamins, etc.	Dosage	Time Per Day

If you have more, you can add them to at the end of this document.

Are these self-prescribed?	Yes	No
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If no, who prescribed them?

Do you drink alcohol?	Yes	No
If yes, how many drinks do you have a:	Day	Week
	Month	Year
What type and size of drink do you drink?		

Do you use non-prescription drug or street drugs (marijuana, Cocaine, LSD, crank, crack, amphetamines, etc.)?	Yes	No
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If yes, please list below what you use and how often below:

Non-Prescription Drugs or Street Drugs	Amount per Day	Amount per Week	Amount per Month	Amount per Year

If you have more, you can add them to at the end of this document.

Do you have any family members or friends that have ever made comments about your use of drugs or alcohol?	Yes	No
Have you ever been confronted by co-workers or employers about your use of drugs or alcohol?	Yes	No
Have you ever lost a job because of your use of drugs or alcohol?	Yes	No
Have you ever had legal trouble because of drug or alcohol use?	Yes	No
Have you ever had financial trouble related to your use of drugs or alcohol?	Yes	No
Have you ever had physical problems (illness, surgeries, accidents, etc.) when using or because of drug and or alcohol use?	Yes	No
Do you have family members who have used drugs or alcohol?	Yes	No
If yes, who?		
How much did they use?		
Did other family members or friends have concerns or make comments about their drug and/or alcohol use?	Yes	No

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How is your diet?			
How many meals a day do you eat?			
How much do you snack during the day?			
How is your appetite:	Good	I eat even when not hungry	I don't get hungry

How are you sleeping?		
Do you fall asleep easily?	Yes	No
How long does it take you to fall asleep?		
Do you wake during the night?	Yes	No
Do you toss and turn while sleeping?	Yes	No
Do you wake up early in the morning before your usual waking time?	Yes	No
Do you have nightmares?	Yes	No
Do you wake up feeling rested?	Yes	No

Were you ever left alone a lot as a child?	Yes	No
When you were a child, did you ever feel very alone even though family was around?	Yes	No
Did your parents help you with problems as a child?	Yes	No
Did you have lot of friends as a child?	Yes	No

Were you ever removed from your home as a child?	Yes	No
If yes, what age(s)?		
Were you ever in a foster home?	Yes	No
If yes, what age(s)?		
Were you ever in a group home or orphanage?	Yes	No
If yes, what age(s)?		

What events that happened as a child or adult still bother you when you remember them now?

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Have you ever been hospitalized for mental or emotional issues?	Yes	No
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If yes, when, what for, for how long and where?

When?	What for?	For How Long?	Where?

Have you had any surgeries?	Yes	No
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If yes, what for and when?

When?	For What?

Have you had any serious illnesses?	Yes	No
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If yes, what illnesses and when?

When?	What illness?

Do you currently have medical problems, any disabilities (emotional, physical or learning), or illnesses?	Yes	No
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If yes, please describe below.

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Do you ever feel there is something very wrong with you and you don't know what?	Yes	No
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If yes, please describe when this feeling comes up.

What are your strengths?

What do you do to create relaxation and a sense of peace in your life? And how often?

Relationship Status

Single	Married	Divorced
In an alternative lifelong commitment?	Please explain:	
Other	Please explain:	

If married or in a long-term commitment for how long?

If divorced, how many times?

And for how long?

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Who do you consider to be important support people in your life? What do they do for you that makes you feel supported?

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Do you have any spiritual beliefs or practice a particular religion?	Yes	No
If yes, please describe what they are.		

Does your spirituality or religion play an important and/or major role in your life?		
	Yes	No
If yes, please describe.		

Please list anything else you feel is important for me to know to be able to provide treatment for you. *Add anything here that you did not have enough room to list earlier in this document.*

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