## Psychotherapy Intake Questionnaire

*Please complete this form to help us understand your needs and provide the best possible care. If you think that a question does not apply to your current situation, you may enter N/A. All information will remain confidential.*

### Personal Information

Full Name(s): _____

Parent/Legal Guardian (if under age 18): _____

Address: _____

Primary Phone: _____ May we leave voice message/text? Yes No

Other Phone: _____ May we leave voice message/text? Yes No

Email: _____ May we send emails? Yes No

*Please note: Email correspondence is not considered a confidential medium of communication*

DOB: _____ Age: _____ Gender: _____

Marital Status: Never Married _____ Domestic Partnership _____ Married _____ Separated _____

Divorced _____ Widowed _____

Children:

Name/Age: _____ Name/Age: _____

Name/Age: _____ Name/Age: _____

Name/Age: _____ Name/Age: _____

Emergency Contact Name & Phone: _____

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**Medical & Mental Health History**

When was your last physical check-up? _____

How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific health problems or medical conditions you want us to know about:

_____

Are you currently taking any medications? □ Yes □ No

If yes, please list: _____

Are you currently experiencing any chronic pain? □ Yes □ No

If yes, please describe: _____

How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific sleep problems you are currently experiencing:

_____

Do you exercise regularly? □ Yes □ No

If yes, what type of exercise? _____

Please list any difficulties you experience with your appetite or eating problems:

_____

Have you received mental health services in the past? □ Yes □ No

If yes, please describe: _____

_____

*(Please include details like name of provider, how long you attended, outcome, etc.)*

Have you ever been diagnosed with a mental health condition? □ Yes □ No

If yes, please explain: _____

Have you ever OR are you currently taking any psychiatric medications? □ Yes □ No

If yes, please list: _____

Are you currently experiencing overwhelming sadness, grief or depression? □ Yes □ No

If yes, please state approximately how long: _____

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Are you currently experiencing anxiety, panic attacks or phobias? □ Yes □ No

If yes, please state when these began: _____

Have you experienced any type of abuse? □ Yes □ No (Check all that apply):

□ Sexual □ Emotional □ Verbal □ Physical □ Spiritual □ Other: _____

Have you experienced any of the following? (Check all that apply):

□ Anxiety □ Depression □ Trauma □ Substance Use □ Other: _____

**Lifestyle Information**

Are you currently employed? □ Yes □ No

If yes, what is your current employment situation? _____

Do you enjoy your work? □ Yes □ No

Is there anything stressful about your work? □ Yes □ No

If yes, please explain: _____

Do you drink alcohol more than once a week? □ Yes □ No

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

If unmarried, are you currently in a romantic relationship? □ Yes □ No

If yes, for how long? _____

On a scale of 1-10, with 1 being poor and 10 being exceptional, how would you rate your relationship? _____

Are you or your partner on **probation/parole**? □ Yes □ No

If yes, please explain the reason: _____

Do you have a support system (friends, family, etc.)? □ Yes □ No

Do you consider yourself to be spiritual or religious? □ Yes □ No

If yes, describe your faith/belief: _____

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

What do you consider to be your strengths?

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_____

What do you consider to be your areas of growth?

_____

**Family Mental Health History**

In this section, identify any family history of the following conditions. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

| | | |
|---|---|---|
| Alcohol/Substance Abuse: | □ Yes □ No | _____ |
| Anxiety: | □ Yes □ No | _____ |
| Depression: | □ Yes □ No | _____ |
| Domestic Violence: | □ Yes □ No | _____ |
| Eating Disorders: | □ Yes □ No | _____ |
| Obesity: | □ Yes □ No | _____ |
| Obsessive Compulsive: | □ Yes □ No | _____ |
| Schizophrenia: | □ Yes □ No | _____ |
| Sexual Deviance: | □ Yes □ No | _____ |
| Suicide Attempts: | □ Yes □ No | _____ |

**Presenting Concerns & Therapy Goals**

What brings you to therapy? How long have you experienced these concerns?

_____

_____

What do you hope to accomplish from therapy?

_____

_____

**Additional Information**

Is there anything else you'd like us to know? _____

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