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: _____

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: _____

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?

_____

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? _____