CONCORDIUM

Client Intake Questionnaire

Please note that information provided on this form is protected as confidential information.

Personal Information

Date: _____

Full Name: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

City:_____State:_____Zip Code: _____

Home Phone:_____May we leave a message? □ Yes □No

Cell/ Other Phone:_____May we leave a message? □ Yes □No

Email: _____

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

DOB:_____ Age:_____ Gender: _____

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred By (if any): _____

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954. 249. 3823 | Barbara@TheConcordium.com
www.TheConcordium.com

Ethnicity: □ African American □ American/Alaskan Indian □ Anglo □ Asian
□ Latino/a □ Pacific Islander □ Other: _____

Religion: □ Buddhist □ Catholic □ Christian □ Hindu □ Jewish
□ Islamic □ Protestant □ None □ Other: _____

Affectional/Sexual Orientation: _____

Gender Identification: _____

Emergency Contact:

Name	Relationship	Phone Number

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ No □ Yes

If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? □ No □ Yes

If yes, please list and provide dates:

_____

_____

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General Information

1. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

2. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, please explain. _____

3. Please list any history or current substance use (drug/alcohol):

Substance	Frequency
Example: Marijuana	**3 times a day**

Family Mental Health 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 (e.g. 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	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	