Please complete this questionnaire to the best of your ability. Please put N/A where something is not relevant to this case. Any information provided will be kept confidential, and will allow me to have the most informed and comprehensive view of the presenting concerns. Please feel free to share with me any concerns or questions you may have about this intake questionnaire.

Date of Form Completion:	
Name of Client:	Phone Number: May I leave messages regarding treatment at the phone numbers listed? Yes / No
Address	
E-mail	Referred by
Names and Ages of Children	
1. 2. 3. 4.	

Areas of Concern

What issues/concerns caused you to seek treatment? Please describe.

What are your specific goals with regard to your treatment?

What will be different or how will you be able to tell if treatment has been successful?

Do you have any particular concerns/fears with regard to treatment? If yes, please explain:

Psychological History. *Please complete in as much detail as possible and provide pertinent information for both parents.*

Have you ever received mental health treatment before? If yes, please share more, including the purpose of the treatment, how long the treatment lasted, thoughts about it, and any ways in which it was helpful.

Name of treating therapist(s), address(es), telephone number(s)

Do you have a history of hospitalization for your mental health? If yes, please describe.

Are you currently taking any prescription medications? If yes, please provide the prescription name, dosage, frequency, and prescribing providers contact information.

Do you have a history of suicidal thoughts?

Are you currently having suicidal thoughts?

Medical History
Please describe your overall health today.

Have you ever been diagnosed with a serious illness? If yes, please provide a brief description.

Do you currently have any medical conditions that you feel may affect your mental health treatment? If yes, please provide a brief description.

Have you ever been in a 12-step program or any other program for treatment of alcohol or drug addiction? If yes, please provide more information here.

Do you smoke? _____ How much? _____ For how long? _____
Do you drink alcohol? _____

On average, how many servings of alcohol do you consume in a week?_____

Do you currently use drugs? If yes, please describe your use:

Did you previously used drugs? If yes, please describe your use:

Has a family member or loved one ever expressed concern about your use of substances or alcohol or asked that you consider quitting?

Family of Origin History
Please indicate any family history of illness (depression, anxiety, postpartum mental illness, substance use, chronic health issues, etc..).

Other Information
Please describe your spiritual identity/orientation or other beliefs that influence your preference for treatment.

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit?

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.