# INTAKE QUESTIONNAIRE

The purpose of this intake is to understand what brings you to therapy so I can help you more effectively. I want to know about **your** experiences and ideas. This intake will ask some questions on what is going on and how you are dealing with it. Please remember there are no right or wrong answers as this is your lived experience.

**DATE:**_________________________

**CLIENT NAME:**___________________________________________ **PREFERRED NAME:**______________________
**CLIENT DATE OF BIRTH**___________________________ **AGE:**___________ **PRONOUNS:**______________________
**SEX ASSIGNED AT BIRTH**___________**IDENTIFIED GENDER:**_____________________
**HOW DO YOU IDENTIFY CULTURALLY?**____________________________________________

**PHONE** ________________________________________ Is it OK to leave a message**?** YES NO Is it OK to text**?** YES NO
**SECONDARY PHONE** ___________________________ Is it OK to leave a message**?** YES NO Is it OK to text**?** YES NO

**STREET ADDRESS**________________________________

**CITY, STATE, ZIP** ________________________________

**E-MAIL** ___________________________________________________________ Is it OK to send a message**?** YES NO
*E-mail is not used to communicate protected health information, as e-mail is not considered to be a confidential form of communication*

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## TREATMENT HISTORY

1) Have you previously received any type of outpatient mental health services (psychotherapy, psychiatric services, etc.)? YES NO
Previous therapist/practitioner_____________________________________________ Dates______________________________

2) Are you currently taking any prescription medication for mood/anxiety/focus management? YES NO
If yes, please list
Medication_____________________________ Dosage_________________ Managing Practitioner _________________________
Medication_____________________________ Dosage_________________ Managing Practitioner _________________________
Medication_____________________________ Dosage_________________ Managing Practitioner _________________________

3) Have you ever been prescribed medication for mood/anxiety/focus management? YES NO
If yes, please list
Medication________________________________________ Reason_________________________ When______________________
Medication________________________________________ Reason_________________________ When______________________
Medication________________________________________ Reason_________________________ When______________________

4) Have you ever been hospitalized or received inpatient treatment for mental health or substance abuse? YES NO
If yes, please list
Reason______________________________________ Dates (approx.)_________________ Location________________________
Reason______________________________________ Dates (approx.)_________________ Location________________________
Reason______________________________________ Dates (approx.)_________________ Location________________________

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## GENERAL AND MENTAL HEALTH HISTORY

5) How would you rate your current physical health?
Poor Fair Good Excellent
Please list any specific health problems you are currently experiencing __________________________________________________

6) Have you ever had any major illnesses, injuries, medical treatments, or surgeries which still affect you today either physically or psychologically? YES NO
If so, please explain____________________________________________ ______________________________________________________

7) Are you currently experiencing any chronic illness or pain? YES NO
If yes, please describe: ______________________________________________________________________________________________

## GENERAL AND MENTAL HEALTH HISTORY (continued)

8) Are you currently experiencing any difficulties or problems with your appetite or eating? YES NO
If yes, please describe: ______________________________________________________________________________________________
Did you ever have an eating/feeding disorder which is now in remission? YES NO

9) How would you rate your current sleep?
Poor Fair Good Excellent
Please list any specific sleep problems you are currently experiencing________________________________________________________
How many hours of sleep do you get each night? _______________

10) How frequently do you exercise? _______________________________________ Type?______________________________________

11) Do you drink alcohol? YES NO
If yes, Type____________________________________ Frequency__________________________ Amount___________________________

12) Do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never
If yes, what substances do you use?___________________________________________________________________________________

| 13) Over the last 2 weeks, how often have you been bothered by the following problems? | NOT AT ALL | SEVERAL DAYS | MORE THAN HALF THE DAYS | NEARLY EVERYDAY |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Worrying too much about different things | 0 | 1 | 2 | 3 |
| Trouble relaxing | 0 | 1 | 2 | 3 |
| Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| | | | | |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling/staying asleep, sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things such as reading the newspaper or watching television. | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| Engaging in impulsive behaviors, such as spending, sex, etc | 0 | 1 | 2 | 3 |
| | | | | |

| | | | | |
|---|---|---|---|---|
| Outbursts of anger or aggression | 0 | 1 | 2 | 3 |
| Feeling refreshed or alert with little or no sleep | 0 | 1 | 2 | 3 |
| Difficulty controlling crying or being overly tearful | 0 | 1 | 2 | 3 |
| Neglecting housework or hygiene due to lack of motivation | 0 | 1 | 2 | 3 |

| 14) To the best of your knowledge, has anyone in your immediate family ever experienced the following mental health/developmental issues whether they were diagnosed or suspected? | | Relationship to you |
|---|---|---|
| Anger/Impulse Control Problems | YES NO | |
| Major Depression | YES NO | |
| Anxiety Disorders (include OCD, panic, and phobias as well) | YES NO | |
| Bipolar Disorder | YES NO | |
| Pervasive Developmental Disorders (e.g. Autism, Asperger's) | YES NO | |
| Alcohol/Substance Abuse | YES NO | |
| Schizophrenia/Psychosis | YES NO | |
| Has anyone close to you committed suicide? | YES NO | |

## SOCIAL HISTORY

15) With whom do you live (circle all that apply): live alone mother father step-parent sibling(s) #____
husband wife Partner minor child(ren) #____
adult child(ren) #____ roommate(s)#____ other_________________

16) If applicable, please answer: Years with current partner/spouse ____________ # of children from relationship _____
Previous significant relationships: Years with former partner/spouse____________ # of children from relationship _____
Years with former partner/spouse ____________ # of children from relationship _____

17) Do you ever feel *unsafe* in your home? YES NO

18) How would you rate the quality of your current support network and friendships?
Poor Fair Good Excellent

19) Are you active in hobbies, activities or interests? YES NO Type_____________________________________________

20) Do you consider yourself to be spiritual or religious? YES NO
If yes, how do your beliefs affect your daily life?
__________________________________________________________________________________

21) Education:
CURRENT K-12 STUDENTS: School attending__________________________________ Grade_____________________

| How are you doing? | *Academically:* | Excellent | OK | Struggling |
|---|---|---|---|---|
| | *Socially:* | Excellent | OK | Struggling |
| | *Attendance:* | Excellent | OK | Struggling |

*If summer, grade recently completed*

If you have an IEP/504 plan, please list accomodations__________________________________________________________________
CURRENT COLLEGE STUDENTS: School attending_________________________________ Level___________________________

| How are you doing? | *Academically:* | Excellent | OK | Struggling |
|---|---|---|---|---|
| | *Socially:* | Excellent | OK | Struggling |
| | *Attendance:* | Excellent | OK | Struggling |

Current Major______________________________________________________________________________________
IF GRADUATED/NOT IN SCHOOL:
Highest level of education completed: HS Diploma GED Associates Trade Certificate Bachelors Masters Doctorate
Degree(s) Held:____________________________________________________________________________________

22) Are you currently employed? YES NO
If yes, employment status: Full time Part time (#hours per week______ )
Employer_____________________________________________ Occupation/Position________________________________________

On a scale of 1 to 10 (with 10 being a very satisfied), please rate your level of job satisfaction? ________________________________
On a scale of 1 to 10 (with 10 being a very secure), please rate your feeling of job security? ___________________________________
On a scale of 1 to 10 (with 10 being a very high amount), please rate the amount of stress in your job currently? __________________

23) If not employed, are you (circle all that apply)
Still in school Looking for work Raising children/running household Retired On Disability/unable to work
Primary caregiver for______________________

24) Have you experienced any significant losses, life changes or stressors in the past year? YES NO
If yes, please explain ______________________________________________________________________________________________
_____________________________________________________________________________________________________________

25) Have you ever been the victim of abuse either as a child or adult (include physical, verbal, emotional, sexual, domestic violence, or neglect as a child)? YES NO

26) By your definition, have you ever experienced a traumatic event or situation that you felt was life changing or still affects you today which was not indicated above? YES NO
If yes, please explain ______________________________________________________________________________________________
_____________________________________________________________________________________________________________

27) Do you have any current or pending legal issues (e.g. DUI, criminal, child custody, divorce, lawsuit, bankruptcy)? YES NO
If yes, please explain ______________________________________________________________________________________________

## ADDITIONAL INFORMATION

28) What helps get you through the day? (Hobbies, people, places, mantras/affirmations, etc.)_______________________________________________________________________________________________________
_____________________________________________________________________________________________________________

29) What do you hope to get out of therapy?______________________________________________________________
_____________________________________________________________________________________________________________

30) What made you seek out therapy at this time? _____________________________________________________________________
_____________________________________________________________________________________________________________

31) Is there anything you would like to focus your goals and treatment on?
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

32) Please share any additional information that you feel would be helpful to know to best help you? ___________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Client Signature:__________________________________Date:_______________

(If applicable) Parent/Guardian Signature:_________________________Date:______________

Clinician Signature:______________________________Date:__________________