Intake Questionnaire

Last Name:
First Name:

Street Address: City: State:
Primary Phone: Alternate Phone: Cell Phone:
E-Mail:

Please indicate which option you prefer to be contacted/you may chose more than one.

Phone:
Text:
E-mail:

Emergency Contact Information:
Name: Relationship:
Phone number: E-mail:

Date of Birth:
Age:

Gender:
Female Male Transgender Trans-male Trans-female Non-binary

Preferred pronoun:
He/him/his She/her/hers They/them/theirs/ Other:

Orientation:
Straight Gay Lesbian Bisexual Asexual Queer Questioning Other

What type of services are you currently seeking?
Individual therapy
Marital/couples therapy
Family therapy
Group therapy
Other (describe)
Unsure

Treatment Goals:
What motivated you to seek therapy for at this time?

Describe your current concerns, issues, and/or problems that you hope to address/resolve in therapy:

Relationship Status:
Currently married or in a relationship: yes no
Divorced: yes no

Source of Income:

Employment Unemployment Spouse/significant other Social Security Short Term Disability Other

Current Employment Status:
Working fulltime Employed part-time Retired On medical leave Unemployed seeking work Full-time student Part-time student

Education Information:
Elementary K-8 Some High School (no diploma) High School Diploma/GED Some College (no degree) Technical/Trade School Associate Degree Bachelor's degree Master's Degree Professional Graduate Degree Doctor's Degree

Military History:

Currently on active duty Veteran Affiliated with military personnel

Legal History:

Have you been ordered by the court to participate in therapy? Yes No
Are you currently involved in any kind of litigation or legal dispute? Yes No
Are you currently on probation or parole Yes No

Previous Mental Health Treatment History:
Have you participated in therapy in the past? Yes No
If YES please complete the information below:
Type of services
Approximate dates of service
Length of treatment

If it is deemed relevant to communicate with previous providers a release of information will be needed.

Medication/Medical History:
Are you currently taking medication? Yes No

If YES please indicate medication(s) and dose:

Name of treating Physician and/or psychiatrist:
Contact Information:

Have you taken medication(s) in the past? Yes No
If YES please indicate medication(s) taken:
Do you have any medical conditions: Yes No
If YES please explain:
Have you ever been hospitalized for mental health reasons? Yes No
If YES please indicate dates and reasons:

Have you had Suicidal thoughts? Yes No
Do you currently have Suicidal thoughts? Yes No
If YES how frequently? For how long?
Have you engaged in Self-injurious Behaviors in the past (cutting, head banging, scratching, burning, etc…)? Yes No
Do you currently engage in Self-injurious Behaviors (cutting, head banging, scratching, burning, etc…)? Yes No
If YES how frequently? For how long?

Have you had thoughts of harming others? Yes No
Do you currently have thoughts of harming others? Yes No

Family History:
Who do you reside with? Name Age Relationship