Intake Questionnaire

Person Completing Form (If other than client): _____

General: Date: _____

Client Full Legal Name: _____

Preferred Name: _____ Preferred Pronouns: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital/Relational Status: _____

Gender:

Woman: ___ Man: ___ Transgender: ___ Transman: ___ Transwoman: ___
Gender Nonconforming: ___ Not Listed: _____

Orientation:

Heterosexual: ___ Gay: ___ Lesbian: ___ Bisexual: ___ Asexual: ___ Queer: ___
Questioning: ___ Not Listed: _____ Prefer not to answer: ___

Relational Preference:

Monogamy: ___ Polyamory: ___ Not Listed: _____Prefer not to answer: ___

Goals of Treatment:

What compelled you to seek therapy at this time?

_____
_____
_____

What do you hope to gain from therapy?

_____
_____
_____

Current Employment Status (Please check all that apply):

Working Full-Time: _____ Working Part-Time: _____ Unemployed: _____
Retired: _____ On medical leave: _____
Full-Time Student: _____ Part-Time Student: _____

Legal History:

Have you been ordered by the court to participate in this therapy, yes or no?
Yes: ____ No: ____ (If yes, you may be required to supply supporting documentation such as a copy of the court order.)

Are you currently involved in any kind of litigation or legal dispute, yes or no?
Yes: _____ No: _____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):
_____
_____

Emergency Contact Information: (Who to contact in case of an emergency)

Name: _____ Relationship: _____
Phone number: _____ Email: _____

Referral Information:

Were you referred? Yes: ___ No: ___ If yes, by whom? _____
May we thank this person for referring you? Yes _____ No _____

Payment Information:

Please indicate how you intend to pay for treatment:
Cash: ____ Check: ____ Credit Card: ____ Third-Party: _____
Insurance (Please indicate name of insurance): _____

<u>If a third-party will be paying for your treatment please provide the following</u>:
Name of the person paying for your therapy: _____
Your Relationship to this person: _____
Contact Information for this person: _____

<u>If you are planning to use health insurance, please provide the therapist with a copy of your insurance card and Photo ID.</u>

Previous Mental Health Treatment History:

Have you participated in therapy previously? Yes: _____ No: ____
Dates of treatment: _____
Focus of treatment: _____

Have you ever been hospitalized for mental health reasons? Yes: ___ No: ___
If yes, please complete the following information:
Reason for hospitalization: _____
Was hospitalization voluntary or involuntary? Voluntary: _____ Involuntary: _____
Dates of hospitalization? _____

Are you currently taking any prescribed psychiatric medication(s)? Yes _____ No_____
If yes, please list the medications and dosages in the space below:

_____
_____
_____
_____
_____

Trauma History (Optional):

Have you been – or are you currently being – emotionally, physically, or sexually abused? Yes _____ No _____ Prefer not to answer _____

If you checked "Yes," you may use the space below to describe the underlying circumstances if you choose to do so:

_____
_____
_____
_____
_____

Spiritual/Cultural History (Optional):

Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:

_____
_____
_____
_____
_____

Do any of the above religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? Yes ____ No ____ If yes, please describe:

_____
_____
_____
_____

Additional Information

Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____