Intake Questionnaire – Adult

** Indicates a required field*

What name do you prefer I call you?

What are your pronouns?

Please describe your current living situation. Do you live alone or with others? Are you happy in your current living situation? Is there anything you would like to change about your current living situation?

_____

_____

_____

Do you have a family history of mental illness? If so, please describe.

Yes; Please describe: _____
No

What brings you to therapy at this time? Is there something specific, such as a particular event? Please be as detailed as you can.

_____

_____

_____

Do you drink alcohol or use recreational drugs? If so, how often?

Yes; How Often: _____
No

Please check any of the following you have experienced in the past six months:

Increased appetite
Decreased appetite
Trouble concentrating
Difficulty sleeping
Excessive sleep
Low motivation
Isolation from others
Fatigue/low energy
Low self-esteem
Depressed mood
Self-harm or cutting

Anxiety
Fear
Hopelessness
Panic
Suicidal Thoughts
Other: _____

If you take prescription medication, who is your prescribing MD? Please include type of MD, name, and phone number.
* Please describe your relationship with your parents and siblings.

_____
_____
_____

Are you in a romantic relationship?
Yes
No

Have you seen a mental health professional before? If so, for how long? Did you find it beneficial?
Yes
No

What is your occupation? How does your job contribute to your mental health?

_____
_____
_____

Please check any of the following that apply
Headache
High blood pressure
Gastritis or esophagitis
Hormone-related problems
Head injury
Angina or chest pain
Irritable bowel
Chronic pain
Loss of consciousness
Heart attack
Bone or joint problems
Seizures
Kidney-related issues
Chronic fatigue

Dizziness
Faintness
Heart valve problems
Urinary tract problems
Fibromyalgia
Numbness & tingling
Shortness of breath
Diabetes
Hepatitis
Asthma
Arthritis
Thyroid issues
HIV/AIDS
Cancer
Other: _____

Has anyone else in your family ever attended therapy? Did they benefit from the experience?

_____

_____

_____

Have you ever been hospitalized for a psychiatric issue?
Yes
No

What are your goals for therapy? Please be as specific as possible.

_____

_____

_____

_____

* Who referred you to my private practice?

_____

* May I send them a thank you note for the referral?
Yes
No

Is there anything else you would like me to know about you?

_____

_____

Intake Questionnaire (Parent)

** Indicates a required field*

How old is your child?

Where does your child go to school and what grade are they in?

Please describe how your child does in school (both academically and socially).

Describe your child's current living situation. Does he/she you live alone, with others. If your child rotates between homes, please describe the custody schedule below.

Has your child seen a mental health professional before? If so, for how long? Was therapy effective for your child?

Yes; How Long: _____

Was it effective? _____

No

If your child takes prescription medication, who is your prescribing MD? Please include type of MD, name, and phone number.

To the best of your knowledge, does your child drink alcohol or use recreational drugs? If so, how are drugs and alcohol discussed at home?

Yes;

How are drugs and alcohol discussed at home?

_____

No

To the best of your knowledge, is your child sexually active? If so, how is intimacy and/or sex discussed at home?

Yes;

How is intimacy/sex discussed at home?

_____

No

Do you have a family history of mental illness? If so, please describe how this history has affected your family or child.

Yes; _____

No

Has your child ever been hospitalized for a psychiatric issue?

Yes

No

To the best of your knowledge, please check any of the following your child have experienced in the past six months:

Increased appetite
Decreased appetite
Trouble concentrating
Difficulty sleeping
Excessive sleep
Low motivation
Isolation from others
Fatigue/low energy
Low self-esteem
Depressed mood
Self-harm or cutting
Anxiety
Fear
Hopelessness
Panic
Suicidal Thoughts

Other: _____

What is your occupation? Please describe how you balance work and family.

_____

_____

_____

What situations or events caused you to seek out therapy for your child at this time?

_____

_____

_____

What elements of your child's developmental history are important for me to know?

_____

_____

_____

Please check any of the following that apply to your child:

Headache
High blood pressure
Gastritis or esophagitis
Hormone-related problems
Head injury
Angina or chest pain
Irritable bowel
Chronic pain
Loss of consciousness
Heart attack
Bone or joint problems
Seizures
Kidney-related issues
Chronic fatigue
Dizziness
Faintness
Heart valve problems
Urinary tract problems
Fibromyalgia
Numbness & tingling
Shortness of breath
Diabetes
Hepatitis
Asthma
Arthritis
Thyroid issues
HIV/AIDS
Cancer
Other: _____

What are your goals for counseling for your teen? What do you think your teen's goals are? Do you have the same or different goals?

_____

_____

_____

_____

Has anyone else in your family ever attended therapy? Did they benefit from the experience?

_____

_____

_____

Who referred you to my private practice?

_____

* May I send them a thank you note for the referral?
Yes
No

* My policy is never to bring up the possibility of taking medication with teens before addressing it with their parents first (even if the teenager brings it up). Therefore, please describe below under what circumstances (if any) you might consider psychiatric medications for your child. Please let me know if this is something you would like to address during our initial phone call.

_____

_____

_____

Has your family ever been to family therapy? If so, was it effective?
Yes
How long? _____
Was it effective? _____
No

What are your child's strengths? How can these strengths help them in therapy?

_____

_____

_____

What do you see as your child's weakness or challenges? How have you learned to work with or address these challenges?

_____

_____

_____

What else would you like me to know about your child?

_____

_____

Intake Questionnaire (Teen)

** Indicates a required field*

What are your goals for therapy? If you got exactly what you needed out of therapy what would we have accomplished together?

_____

_____

_____

_____

What situations or events that encouraged you to seek out therapy at this time?

_____

_____

_____

Are you in a relationship? If so, please describe the nature of the relationship and amount of time together.

Yes; Please describe: _____

No

Describe your current living situation. Do you live alone, with others. With family, etc...

_____

_____

_____

Who is in your support system?

_____

_____

_____

Have you seen a mental health professional before?

Yes

No

Do you have a family history of addiction? If so, please describe any impact it has had on your life.

Yes; Please describe: _____

No

Is there a history of mental illness in your family? If so please describe any impact it has had on your life.

Yes; Please describe: _____
No

Do you have a job? If so, where do you work?

Yes; Please describe: _____
No

If you are in school or college, please describe how you are doing academically in your classes.

_____
_____
_____

Do you drink alcohol? If so, how much and how often?

Yes; How Often: _____
No

Do you use drugs?

Yes; How Often: _____
No

Have you ever been hospitalized for a psychiatric issue?

Yes
No

Do you currently have suicidal thoughts?

Yes
No

What is your favorite thing about yourself?

_____
_____
_____

Have you ever attempted suicide?

Yes
No

Do you have thoughts or urges to harm others?

Yes
No

Please check any of the following that apply

Headache
High blood pressure
Gastritis or esophagitis
Hormone-related problems
Head injury
Angina or chest pain
Irritable bowel
Chronic pain
Loss of consciousness
Heart attack
Bone or joint problems
Seizures
Kidney-related issues
Chronic fatigue
Dizziness
Faintness
Heart valve problems
Urinary tract problems
Fibromyalgia
Numbness & tingling
Shortness of breath
Diabetes
Hepatitis
Asthma
Arthritis
Thyroid issues
HIV/AIDS
Cancer
Other: _____

Please check any of the following you have experienced in the past six months
Increased appetite
Decreased appetite
Trouble concentrating
Difficulty sleeping
Excessive sleep
Low motivation
Isolation from others
Fatigue/low energy
Low self-esteem
Depressed mood
Self-harm or cutting
Anxiety
Fear
Hopelessness

Panic
Suicidal Thoughts
Other: _____

Do you do any extracurricular activities? If so, which ones?

_____
_____
_____

* What are your strengths?

_____
_____
_____

Where do you feel most peaceful?

_____
_____
_____

Please tell me about your relationship with your parents.

_____
_____
_____

Is there anything else you would like me to know about you?

_____
_____
_____