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?

_____

_____

_____