

Intake Information (to be completed by client)

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for treatment.

Name: _____ Date of Birth: _____

Address: _____

Telephone number(s): Home: (____) _____ Work: (____) _____

Can I leave a message at home? YES NO at work? YES NO

Can you be reached by Email? YES NO Email address: _____

When is the best time to send Email to you? _____

Occupation: _____

Employer: _____

Highest level of education: _____

How satisfied are you with your job? _____

Briefly describe your reason(s) for seeking help at this time: _____

What do you wish to accomplish through the process of therapy? _____

Approximately how many visits do you think it will take? _____

Marital/Relationship Status (check all that apply):

- Married Separated Widowed Divorced Remarried
 Single Long term relationship Cohabiting Other _____

Current partner's name: _____

Partner's occupation: _____

Length of relationship: _____

How satisfied are you with this relationship? _____

Do you have any children (biological, adopted, foster, step, etc.)? YES NO

If yes, please list names and ages: _____

Do your children currently live with you? YES NO

If no, where do they live? _____

How often do you see them? _____

If you have been previously married, please complete the following:

1st marriage: Date began: _____ Date ended: _____

Ex-spouse's name: _____

Children: YES NO

Reason for divorce: _____

2nd marriage: Date began: _____ Date ended: _____

Ex-spouse's name: _____

Children: YES NO

Reason for divorce: _____

Have you ever been in therapy before? YES NO

If yes, briefly describe the reason(s), date(s), and length of treatment: _____

Was it a positive experience? YES NO

What did you like/not like about it? _____

Have you ever attempted suicide? YES NO

If yes, please describe briefly: _____

Have you ever seriously contemplated suicide? YES NO

Are you currently having suicidal thoughts? YES NO

Do you have any chronic illnesses, medical conditions, or injuries? YES NO

If yes, please describe: _____

Are you presently taking any medication? YES NO

If yes, please list: _____

What do you enjoy doing in your spare time? _____

Are there things that you used to do, or would like to do, but currently don't? _____

How would you describe your spiritual or religious beliefs? _____

Is there anything else you think would be important for me to know about you or your family?

Did someone refer you? YES NO

If yes, who? _____

May I contact him or her? YES NO

Please circle any of the following that presently cause you difficulty:

- | | | | |
|----------------|-----------------|----------------|-------------------|
| Assertiveness | Health problems | Career choices | Stomach problems |
| Parenting | Alcohol use | Legal matters | Self-concept |
| Bowels | Sexual problems | Marriage | Religion |
| Nightmares | Loneliness | Concentration | Separation |
| Bedwetting | Ulcers | My thoughts | Suicidal thoughts |
| Nervousness | Energy | Sleep | Decision making |
| Physical abuse | Children | Parents | Insomnia |
| Education | Divorce | Relaxation | Ambition |
| Temper | Depression | Sexual abuse | Shyness |
| Stress | Inferiority | Friends | Dating |
| Memory | Drug Use | Headaches | Tiredness |
| Headaches | Finances | Appetite | School |
| Unhappiness | Fears | Work | Confusion |
| Premarital | Food | Self-control | Sadness |
| In-laws | My past | Guilt | Other |
- _____
- _____

Now put an * by the items that are causing you the MOST difficulty.