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Intake Questionnaire

Date: _____

Name:

_____

Who referred you? _____ Phone: _____

Address: _____

City, State, Zip: _____

My I contact them to thank them for the referral? ____ Yes ____ No

What issues do you want to address in therapy? _____

_____

_____

_____

_____

_____

_____

Have you been in therapy before? ____ Yes ____ No If yes, with whom and for what?

Name: _____ Dates: _____ Issue: _____

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Have you addressed the issues you came here for in therapy before? ____ Yes ____ No

If yes, what were the results? _____

_____

_____

Are you currently on any medications? ____ Yes ____ No If yes, list all medications, dosages, and times of day you take them.

Med: _____ Dosage: _____ Times: _____

Who prescribed this med? _____ Phone #: _____

Med: _____ Dosage: _____ Times: _____

Who prescribed this med? _____ Phone #: _____

Med: _____ Dosage: _____ Times: _____

Who prescribed this med? _____ Phone #: _____

Med: _____ Dosage: _____ Times: _____

Who prescribed this med? _____ Phone #: _____

Med: _____ Dosage: _____ Times: _____

Who prescribed this med? _____ Phone #: _____

Med: _____ Dosage: _____ Times: _____

Who prescribed this med? _____ Phone #: _____

Are you on any herbs, homeopathy, vitamins, etc? ____Y ____ No If yes, please list what you take, dosage and times a day.

_____ Dosage: _____ Times: _____

_____ Dosage: _____ Times: _____

_____ Dosage: _____ Times: _____

_____ Dosage: _____ Times: _____

_____ Dosage: _____ Times: _____

_____ Dosage: _____ Times: _____

_____ Dosage: _____ Times: _____

Are these self prescribed? ____ Yes ____ No If no, who prescribed them? _____

_____

Do you drink alcohol? ____ Yes ____ No If yes, how many drinks do you have a

_____ day _____ week _____ month ____ year. What type and size of drink do you drink:

_____

Do you use non-prescription drug or street drugs (marijuana, Cocaine, LSD, crank, crack, amphetamines, etc.)? ____ Yes ____ No If yes, please list what you use and how often:

_____ _____ /day _____/week _____/month _____/year

_____ _____ /day _____/week _____/month _____/year

_____ _____ /day _____/week _____/month _____/year

_____ _____ /day _____/week _____/month _____/year

_____ _____ /day _____/week _____/month _____/year

Do you have any family members or friends that have ever made comments about your use of drugs or alcohol? ____ Yes ____ No

Have you ever been confronted by co-workers or employers about your use of drugs or alcohol? ____ Yes ____ No

Have you ever lost a job because of your use of drugs or alcohol? ____ Yes ____ No

Have you ever had legal trouble because of drug or alcohol use? ____ Yes ____ No

Have you ever had financial trouble related to your use of drugs or alcohol? ____ Yes ____ No

Have you ever had physical problems (illness, surgeries, accidents, etc.) when using or because of drug and or alcohol use? ____ Yes ____ No

Do you have family members who have used drugs or alcohol? ____Yes ____ No If yes, who? How much did they use? _____

_____

_____

_____

Did other family members or friends have concerns or make comments about their drug and/or alcohol use? ____ Yes ____ No

How is your diet? _____

How many meals a day do you eat? _____

How much do you snack during the day? _____

How is your appetite: _____ I eat even when not hungry _____ Good _____ I don't get hungry

How are you sleeping? _____

Do you fall asleep easily? _____ Yes _____ No

How long does it take you to fall asleep? _____

Do you wake during the night? _____ Yes _____ No

Do you toss and turn while sleeping? _____ Yes _____No

Do you wake up early in the morning before your usual waking time? _____ Yes _____ No

Do you have nightmares? _____ Yes _____ No

Do you wake up feeling rested? _____ Yes _____ No

Have you ever had sexual relations with someone whom you did not want to?

____ Yes ____ No

Were you ever touched sexually as a child? ____ Yes ____ No

Did you ever have sexual interactions as before 18 years of age? ____ Yes ____ No

Were you ever physically hurt by adults as a child? ____ Y ____ No

Were you ever left alone a lot as a child? ____ Y ____ N

When you were a child did you ever feel very alone even though family was around?

____ Y ____ N

Did your parents help you with problems as a child? ____ Y ____N

Did you have lot of friends as a child? ____ Y ____ N

Were you ever removed from your home as a child? ____ Y ____ N If yes, what ages? _____

Were you ever in a foster home? ____ Y ____ N If yes, what ages? _____

Were you ever in a group home or orphanage? ____ Y ____ N If yes, what ages? _____

What events that happened as a child or adult still bother you when you remember them now?

_____

_____

_____

_____

Have you ever been hospitalized for mental or emotional issues? ____ Yes ____ No If yes, when, what for, for how long and where?

When?	What for?	How long?	Where?

Have you had any surgeries? ____ Y ____ N If yes, what for and when?

What for?	When?

Have you had any serious illnesses? ____ Y ____ N If yes, what illnesses and when?

Do you currently have medical problems, any disabilities (emotional, physical or learning), or illnesses? ____ Y ____ N If yes, please describe. _____

Do you ever feel there is something very wrong with you and you don't know what?

____ Yes ____ No If yes, please explain when this feeling comes up. _____

What are your strengths? _____

What do you do to create relaxation and a sense of peace in your life? And how often?

Circle one:

Are you: Married In an alternative life long commitment Single Divorced?

If married or in alternative life long commitment for how long? _____

If divorced? ____ Y ____ N If yes, how many times? _____ For how long? _____

Who do you consider to be important support people in your life? What do they do for you that makes you feel supported? _____

Do you have any spiritual beliefs or practice a particular religion? ____ Yes ____ No If yes, please describe what they are.

Does your spirituality or religion play an important and/or major role in your life?
____ Yes ____ No If yes, please describe.

Please list anything else you feel is important for me to know to be able to provide treatment for you?