

Confidential Client Intake Information Questionnaire

■ Name _____ Age _____ Birthdate _____

Address _____

Home phone _____ Work phone _____

Other phones _____

Is it OK to contact you on these #'s No Yes If no, how can I contact you? _____

E-mail address _____

■ Birthplace _____ Marital status _____

of times married _____ # years in current marriage _____

Occupation _____

Employer _____

Education _____

■ Spouse's name _____

Spouse's Occupation _____ Spouse's Employer _____

How many children do you have?

| | | |
|------------|-----------|--|
| Name _____ | Age _____ | Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Name _____ | Age _____ | Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Name _____ | Age _____ | Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Name _____ | Age _____ | Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Name _____ | Age _____ | Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes |

■ Religion/Ethnicity/Gender issues of note _____

■ Who referred you _____

Family doctor _____

List any major health problems _____

Please list any medications you take _____

Have you been in therapy before? No Yes

If yes, when? For what issues? _____

Whom did you see? Did it help? (explain) _____

■ Please check any of the following that are currently troubling you:

- | | | | | |
|---|--|---------------------------------------|--|--|
| <input type="checkbox"/> inferiority feelings | <input type="checkbox"/> separation | <input type="checkbox"/> depression | <input type="checkbox"/> friends | <input type="checkbox"/> ACOA |
| <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> anger | <input type="checkbox"/> divorce | <input type="checkbox"/> confidence | <input type="checkbox"/> work |
| <input type="checkbox"/> making decisions | <input type="checkbox"/> sleep | <input type="checkbox"/> alcohol use | <input type="checkbox"/> unhappiness | <input type="checkbox"/> tiredness |
| <input type="checkbox"/> health problems | <input type="checkbox"/> relaxation | <input type="checkbox"/> compulsions | <input type="checkbox"/> stress | <input type="checkbox"/> sadness |
| <input type="checkbox"/> stomach trouble | <input type="checkbox"/> energy | <input type="checkbox"/> self-control | <input type="checkbox"/> phobias | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> career choices | <input type="checkbox"/> legal matters | <input type="checkbox"/> ambition | <input type="checkbox"/> extreme fatigue | <input type="checkbox"/> fetishes |
| <input type="checkbox"/> concentration | <input type="checkbox"/> marriage | <input type="checkbox"/> headaches | <input type="checkbox"/> panic attacks | <input type="checkbox"/> conflict |
| <input type="checkbox"/> being a parent | <input type="checkbox"/> nervousness | <input type="checkbox"/> insomnia | <input type="checkbox"/> overweight | <input type="checkbox"/> self-esteem |
| <input type="checkbox"/> painful thoughts | <input type="checkbox"/> loneliness | <input type="checkbox"/> agoraphobia | <input type="checkbox"/> sexual abuse | <input type="checkbox"/> homicidal |
| <input type="checkbox"/> drug use/abuse | <input type="checkbox"/> education | <input type="checkbox"/> appetite | <input type="checkbox"/> abused as a child | <input type="checkbox"/> no interests |
| <input type="checkbox"/> children | <input type="checkbox"/> guilt | <input type="checkbox"/> fears | <input type="checkbox"/> battered/beaten | <input type="checkbox"/> impotence |
| <input type="checkbox"/> shyness | <input type="checkbox"/> bowel trouble | <input type="checkbox"/> finances | <input type="checkbox"/> temper | |

■ At any time in your life, have you thought about hurting or killing yourself? No Yes

Did these thoughts include a plan and serious intent? If so, when and what were some of the details?

Please describe briefly your reasons for seeking psychological consultation or therapy

What do you hope to get out of this consultation

Is there any more information that you think is important for me to know

Please be aware that **cash or checks** are the only form of payment accepted by the office. Full payment is expected at the time of your visit. If you have health insurance that covers psychological treatment please discuss this with the office staff to inquire about coverage and fill out the required forms. We generally operate very much on time so please be prompt for your appointment or your appointment may be cut short due to starting late.

Since your appointment time is reserved **exclusively for you**, or cancellation policy is as follows:

Appointments must be canceled 24 hours in advance. Appointments which are not given a 24 hour notice and/or missed appointments without cancellation will be subject to the full fee, as if the appointment was kept. Since insurance companies do not pay for missed appointments, this fee is the sole responsibility of the person responsible for payment, and cannot be billed to your insurance. Thank you for your cooperation.

■ Signature of Responsible Party

SSN

■ For clinical use only

Diagnosis
