

## 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: \_\_\_\_\_

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

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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.