Patient Questionnaire/Intake

Name _____ Date _____
Address _____ Home phone _____
Work phone _____ Fax _____
E-mail _____ Referred by _____
Age _____ Date of birth _____
Marital status _____ Educational level _____
Occupation _____ Names and ages of children _____

Emergency contact information _____
Explanation of how patient may be contacted by therapist _____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____

Do you have any specific goals with regard to your treatment? _____

Do you have any particular concerns/fears with regard to treatment? _____

Psychological History:

Have you ever received mental health treatment before? _____
When and for how long? _____
What was the focus of treatment? _____
Name of treating therapist(s), address(es), telephone number(s) _____

Have you ever been hospitalized for mental or emotional problems? _____
When and for how long? _____
Why were you hospitalized? _____
Name of treating therapist, address, telephone number _____
Are you currently taking any prescription medications? _____
Prescribed by whom? _____
How long have you been on the medications? _____
Have you ever taken any medications for a mental or emotional condition? _____
When and for how long? _____
Have you ever attempted suicide? _____
When? _____
Describe the circumstances that led to that attempt. _____

Are you currently having any suicidal thoughts? Please describe _____

Please describe your childhood. _____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

Have you ever been a victim of a violent crime? Please describe _____

Medical History

Have you ever been diagnosed with a serious illness? Please describe _____

Do you have any medical conditions that may affect your mental health treatment? _____

Please describe your overall health today. _____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

Have you ever been in a 12-step program? Please describe. _____

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____

On average, how much alcohol do you consume in a week? _____

Do you currently use illegal drugs? Please describe your use _____

Have you ever used illegal drugs? Please describe. _____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. _____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. _____

Names and ages of siblings. _____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe. _____

_____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____

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