

Intake Information

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

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

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

Cell: (____) _____ Where can I leave messages? Home Work Cell

Can I contact you by email? Yes No Email address _____

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: _____

Marital/Relationship Status (check all that apply):

- Married Separated Widowed Divorced Remarried
 Single Long term relationship Co-habiting 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 married: _____ Date ended: _____

Children: Yes No Ex-spouse's name: _____

Reason for divorce: _____

2nd marriage: Date married: _____ Date ended: _____

Children: Yes No Ex-spouse's name: _____

Reason for divorce: _____

Have you ever been in therapy/counseling before? Yes No

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

Was it a positive experience? Yes No

What was helpful about it? _____

Have you ever attempted suicide? Yes No

Are you currently having suicidal thoughts? Yes No

Are you presently taking any medication? Yes No

If yes, please describe: _____

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

If you were not referred by someone, how did you find my practice? _____

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
Energy	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Sleep difficulties	Infertility	Decision making
Physical abuse	Children	Parents	Sexual orientation
Education	Divorce	Relaxation	Infidelity
Temper	Depression	Sexual abuse	Shyness
Stress	Inferiority	Friends	Dating
Memory	Drug use	Headaches	Tiredness
Finances	Appetite	Concentration	Unhappiness
Fears	Worry	Work	Confusion
Premarital	Food	Relationships	Self-control
Sadness	Grief/loss	In-laws	My past
Guilt	Eating disorder	Lack of self-confidence	

Other: _____

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