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Confidential Intake Questionnaire

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Female/Male _____

SS#: _____ Race/Ethnicity: _____ Religion: _____

Languages Spoken/Preferred Communication Method? (Please circle all that applies)

English Spanish Filipino ASL Other _____

Home Phone: _____ Work Phone: _____

Address: _____

City, State, Zip Code: _____

Contact Information of someone who will know how to reach you: _____

Relationship: _____

RELATIONSHIP STATUS: (please circle all that apply)

Single, not dating separated from partner or spouse living with a partner

Single, dating divorced widowed married

Who lives in your home with you? List names, ages, and relation to you. _____

Do you have children who don't live with you? If so, list names, ages, and where and with whom they live: _____

MEDICAL HISTORY FORM

Your records are confidential. Your records will not be released to any party without your written consent.

Directions: Please answer the following questions to the best of your knowledge.

Name: _____

Medical Insurance: YES NO Carrier: _____

Carrier's Address: _____

_____ Carrier's Phone#: _____

Name of Insured: _____ Insured's Soc. Sec.#: _____

Do you have a doctor you usually see for medical services? If so, write his or her name and number below: _____

When was the last time you had a general medical checkup? _____

Are you pregnant? NA YES NO If YES, how many months? _____

Are you currently being treated for any health problems or recovering from any injury, surgery, etc.? If so, briefly describe here: _____

Medications (List more on separate page if necessary)

Current Medications	For what condition? (What For?)	Dosage (How much?)	Frequency (How often?)	Started taking when?	Comments / Problems / Concerns

Past Medications / For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc.)

Medication Allergies? YES NO (please circle one)

If yes, what medication(s) _____

Do you have any allergies (Substance or Food Allergies)? YES NO (please circle one)

Is yes, what substance(s) _____

SOCIAL / SEXUAL RISK HISTORY

__ YES __ NO Do you smoke? If yes, how many cigarettes per day? _____

__ YES __ NO Do you use alcohol? If yes, how often, how much? _____

__ YES __ NO Do you or your partner(s) use drugs? If yes, how much, how often?
Ever injected drugs? (explain) _____

__ YES __ NO Are you currently in recovery from an alcohol or drug problem?
If YES, have you ever relapsed YES NO If YES, how many times ____

__ YES __ NO Have you ever had or would you like help now with an alcohol or drug problem?

__ YES __ NO Would you like to discuss problems to a rape or emotional/physical/sexual abuse?

__ YES __ NO Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

FAMILY HISTORY: Please check if your family has a history of:

- __ Diabetes (Sugar) __ High Blood Pressure __ Heart Attack, Heart Disease __ Cancer
- __ Alzheimer's __ Tuberculosis __ Blood Clots or Stroke __ Mental Illness
- __ Epilepsy/Seizure __ Family History Unknown

Any other major conditions? _____

If you answered YES to any of the above, please explain: _____

PERSONAL HISTORY:

Have you ever experienced a head injury, concussion, or been “knocked out” or unconscious? YES NO

Have you ever experienced an extremely high fever (over 103 degrees)? YES NO I don’t know

Were there any complications before, during or just after your birth? YES NO I don’t know

List any major illnesses or surgeries you have experienced: _____

Are you currently seeing any other professional counselors or therapists for psychological services? Y N

Briefly describe why you are seeking psychological services: _____

How long have you had these concerns or problems? _____

Have you seen a psychiatrist, psychologist, or mental health counselor in the past? YES NO

If so, briefly describe: _____

FAMILY HISTORY:

Where were you born? _____

Raised? _____

By biological parents? _____

Brothers/Sisters? _____

How would you describe your relationship with your family? Are you close to your parents & siblings?

Was your family religious? If so, which religion did they belong to? If you attended church, how often?

EDUCATION:

Where do you go to school? _____

How far did you go in school? (Educational level) _____

How are your grades in school? _____

How do you feel about going to school? (Positive/Negative Feelings) _____

How would your teachers describe you? _____

If they were asked to say something negative? _____

How would you characterize yourself as being pretty social, or do you think you are more of a loner?

What group do you hang out with? _____

What did you get in trouble for doing in school? _____

Were you ever suspended or expelled from school? _____

What are your successes and failures in school? _____

What are your strengths and weaknesses in school? _____

EMPLOYMENT HISTORY:

Currently employed? YES NO If so, what is your present job? _____

Employer: _____

Business Address: _____

How long on that job? _____

What did you do before you worked (name present job)? _____

What is the longest period of time you have held the same job? _____

How would your bosses describe you? _____

If they were asked to say something negative? _____

Are there any communications problems between you and your boss/co-workers? If so, please explain_____

Tell me about a job you were terminated from. _____

If you could have a job that you think suits your abilities best, not necessarily what you are doing now, what would that job be? _____

RELATIONSHIP HISTORY

How many serious relationships have you had? _____

Of those, do you think you've ever been truly in love? If yes, how do you know? _____

Have there been incidents of infidelity in your relationship? _____

SUBSTANCE ABUSE HISTORY

If SOL client, ask for a release of their substance abuse intake form. Otherwise, proceed with the following section:

Indicate if no history of use _____ or History unknown _____

Has there ever been a period of time in your life when you've thought to yourself, "I think I might be drinking too much"? _____

Have you ever used meth or crystal? _____

Just before you get into a fight (argument) with someone, do you think your heart rate increases, or does your body actually calm down? _____

Are you court-ordered to attend therapy? YES NO

If YES, by whom/Social Worker/Probation Officer: _____

Contact Info/Phone: _____

RELATIONSHIP OFFENSE HISTORY

Have you ever experienced your parents or other adults fighting? YES NO

If so, what did they do? _____

If yes, when was the first episode of aggression or physical abuse in your relationship? _____

Have there been incidents of sexual aggression between you and your partner? _____

Have you ever had a TRO/ RO against you? Do you now? _____

PSYCHIATRIC HISTORY

If the client answered YES to having seen a therapist before ask: Did you get anything out of it, or do you think it was basically a waste of your time? _____

Has there ever been a period of time when you've though you might be down or blue or maybe even depressed? _____

Do you think you've ever really hurt anyone emotionally? _____

Have things ever gotten so bad for you that you've thought about killing yourself? _____

Have you ever threatened to kill yourself after a conflict with your partner? _____

Have you ever tried to kill yourself? _____

Have you ever been psychiatrically hospitalized? _____

Do you ever feel like you won't be able to make it without your partner? _____

When was the last time you cried? _____

When we talk about self-esteem, kind of the way a person values him/her self, where would you place yourself on a scale of 1-10? _____

What didn't I ask that would be helpful to know about you? _____

What question do you have for me? _____

What are your goals for therapy? _____
