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CLIENT INITIAL INTAKE QUESTIONNAIRE

- Provide copy of insurance card and driver's license, if insurance client
- Client's name: _____
- Street Address: _____
- Phone number (home, cell, work): _____
- Email address: _____
- Birthdate: _____
- Age: _____
- Gender (optional): _____
- Orientation (optional): _____
- Ethnicity (optional): _____
- Religious Background (Mother's Side and Father's Side): _____
- Referred by: _____
- Marital status and length of marriage if applicable: _____
- Occupation: _____
- Employers name and number: _____
- Highest level of education: _____
- Ages of siblings and birth order: _____
- Names of person's living in Client's household _____
  _____
- Date of last physical and dental exam: _____
- Physician's name and telephone number: _____
- Medical issues: _____
- Medications (dosage/frequency, period taken, reactions): _____
  _____
- Allergies: _____
- Symptoms: Circle if relevant. Then, next to the symptom, indicate
  - Onset
  - Frequency: Daily (D), Weekly (W), or Monthly (M)
  - Intensity: (on a scale of 1-10)
  - Duration
  - Body Aches
  - Afraid/Anxious/Shy
  - Nightmares
  - Worries
  - Pull out hair
  - Preoccupied with death
  - Don't like new places/people
  - Obsessive thinking
  - Repetitive behaviors
  - Rocking, head-banging
  - Repeated movements, hand-shaking
  - Oversensitive to cold/noise/clothes
  - Smell everything
  - Stay off by myself

- Few or no peer relationships
- No eye contact
- Gender identity questions
- Sexual orientation questions
- Considerate of other's feelings
- Share with others
- Volunteer to help others
- Aggressive/Angry
- Start physical fights/hurt others
- Cruel to animals
- Steal
- Destroy things
- Set fires, play with matches
- Lying/Dishonesty
- Run away, escape
- Accident prone
- Very little energy/ Too much energy
- Seem to hear things
- Sexualized behavior
- Wet/soil myself
- Eat too much/ Eat too little
- Sleep too much/ Sleep too little
- Unhappy, sad, cry
- Loss of interest in things
- Guilt
- Loss of Control
- Blackouts
- Weight loss/ Weight gain
- Hurt myself
- Worry about my body image
- Speech problems
- Hearing problems/ Vision problems
- Don't talk enough
- Academic problems (specify)
- Work problems (specify)
- Difficulty being on time
- Difficulty learning
- Difficulty concentrating/ Easily distracted
- Impulsive
- Difficulty paying attention
- Difficulty listening
- Forgetful
- Fidget/Squirm
- Talk excessively
- Bullied by others/Bully others

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- How are these symptoms/behaviors a problem? How do they impact your life:
  _____
  _____
  _____
- Personal strengths, things that you're proud of and like about yourself, extracurricular activities: _____
  _____
  _____
- Have you experienced trauma?
  - History of domestic violence: _____
  - Physical hurt or threatened by another: _____
  - Been raped or had sex against your will: _____
  - Emotional abuse/neglect: _____
  - Witnessed community violence: _____
  - Been in a natural disaster: _____
  - Been in an accident: _____
  - Experienced a loss: _____
  - Divorce/separation own relationship(s), parents' relationship: _____
    _____
  - Witnessed death of or violence toward another person: _____
  - Been a victim of crime: _____
  - Had any medical procedures or surgeries: _____
  - Immigration: _____
  - Any other trauma: _____
- Do you have any homicidal thoughts or intent to hurt another person _____
- Do you have any suicidal thoughts _____
  - Intent
  - Plan
  - Access to lethal means
  - Knowledge of any other person who has suicide
  - Onset of thoughts
  - Frequency of thoughts
  - Intensity of thoughts
  - Duration of thoughts
  - Protective factors (things that stop or prevent you from harming yourself)
- Have you ever tried to kill yourself or hurt yourself
  _____
- Have you ever had a psychiatric hospitalization? Date? Location? Reason _____
  _____
- Have you ever had any other kind of hospitalization _____
- Are you currently receiving any mental health services _____
  _____
- Have you ever received mental health services in the past _____
  _____
- What were your previous psychological diagnoses (e.g. Major Depressive Disorder)
  _____

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- Name and number of past/present mental health service providers _____
  _____
- What did you like/dislike about past psychotherapy experiences _____
  _____
- Have you in the past or do you currently use alcohol or drugs _____
  - Triggers of use
  - Onset of use
  - Frequency of use
  - Length of use
  - Overdose
- Have you ever received professional help for use of alcohol or drugs _____
- Have you ever had any legal problems_____
- Have you ever been arrested/incarcerated _____
- Have you ever been involved in a Department of Children and Family Services case _____
  _____
- Do your family members have any history of mental illness _____
- Do your family members have any history of alcohol/drug abuse _____
- Do your family members have any history of incarceration _____
- Do your family members have any medical problems _____
- How attached to you feel to your family members _____
- How do you remember your childhood_____
- What do you like about your family _____
- What do you dislike about your family _____
- How were you disciplined growing up _____
- Describe your current concerns, issues, or problems that you hope to resolve _____
  _____
  _____
- What are your goals in coming to therapy _____
  _____
- What do you hope to gain by coming to therapy _____
  _____
- Is there anything else that you feel it would be important for Therapist to know _____
  _____
  _____
  _____