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INTAKE QUESTIONNAIRE

Name: _____ **Address:** _____

City:_____**State:**_____**Zip:**_____

Email address:_____

How were you referred here?_____**If internet, what site?**_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:**_____

1. **Age** _____ **Date of Birth**_____
2. **City/State of birth:**_____
3. **Where did you grow up:**_____
4. **Are your parents alive? Yes____No____. Are you in contact with them? Yes____No____.**
5. **How many siblings do you have?** _____
6. **Please list starting with the oldest and include yourself** _____.
7. **Which siblings are you in contact with? Please circle above.**
8. **Are you: Single ____Married_____ Divorced_____**
9. **How many times have you been married/long term relationships?** _____.
10. **Please list names of previous spouses/partners** _____.
11. **How many times have you been divorced/separated?** _____.
12. **From who?** _____
13. **Who is in your life presently?**

_____

14. **What family members are you close to?**

_____

15. **What family members are you distant from?**

_____

16. **Do you have children? Yes____No____ How Many:** _____.

    Please list names of children and ages starting with the youngest:

    _____

17. **What is your occupation?**_____**Full or part-time?**_____
18. **What is your religion, if any?**

_____

19. **What are your hobbies?** _____
20. **Please list those in your support system:**

_____

21. **Do you have any history of abuse? Yes____No____**

22. **What type of abuse have you experienced?**

    Physical____ Verbal____ Sexual____ Neglect____ Domestic____ Emotional/Psychological _____

    Are you presently in therapy? Yes____No____

    Please list present therapist: _____

23. **Past therapy/psychiatric Experiences? Yes____No____**

24. **Duration of therapy in past? _____ (Please list names of all previous treatment practitioners/psychiatrists)_____**

25. **Are you presently under the care of a psychiatrist? Yes____No____**

26. **Are you presently on psychiatric medication(s)? Please list:**

_____

27. **Are you presently under care of a medical doctor? Yes____No___**

28. **Are you presently on any medical medication(s)? Please list:**

_____

29. **Have you had any psychiatric hospitalizations? Yes____No_____ Please list all hospitalizations and duration:_____**

30. **Please list any medical hospitalizations**

_____

31. **Do you have legal problems? Yes____No____ please list any legal problems**

_____

32. **Please check any of the following symptoms which apply to you:**

    Compulsive____
    Annoyance____
    Anger____
    Difficulty sharing____
    Giving too much____
    Anxiety____
    Sweating____
    Breathing problems____
    Missing appointments____
    Dramatic____
    Unstable____
    Intense____
    Commitment____
    Gambling____
    Depression____
    Loss____
    Bad dreams____
    Trauma____
    Stress____
    Euphoria____
    Crying____
    Violence____
    Mood swings____
    Not caring about anything____
    Infidelity ____
    Fear(s) ____
    Decreased interest in pleasurable activities____
    Sleep disturbance____
    Appetite disturbance____
    Motivation problems____
    Panic____
    Guilt ____
    Hopelessness____
    Worthlessness ____
    Fatigue ____
    Restlessness ____

Difficulty concentrating ____
Isolation ____
Sexual problems ____
Arguing____
Agitation____
Thoughts of death ____
Plans for suicide ____
Rage____
Thoughts of hurting others____
Thoughts of hurting self____
High self esteem ____
Talkative____
Foolish spending habits ____
Visual hallucinations____
Auditory hallucinations____
Suspiciousness____
Distracted ____
Racing Thoughts ____
Paranoia ____
Voices ____
Dependency ____
Jealousy ____
Bossiness____
Disappointment____
Frustration____
Fetishes ____
Orderliness____
Pain____
Drugs____
Past hx. of drugs____
Memory problems____
Impulsive thoughts____
Financial stressors____
Repetitive behaviors____
Difficulty completing things____
Problems keeping friends____
Intimacy issues____
Learning disorders____
Grooming & Hygiene____

Please list any issues or problems that were not on the checklist that you would like to address:

_____

33. Please describe the reason you are seeking therapy.

What goals in therapy would you like to achieve?

_____

_____

34. How long do you see yourself needing to achieve these goals? 1-3 months ____ 3-6 months ____ 6-8 months ____.

35. Why are these goals important? _____

36. Please list any other comments in order to help identify problem areas:

_____

_____

37. Who else would you like to include in your treatment?

_____

Thank you for taking the time to completely fill out this form.