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Initial Intake Questionnaire

Client Name(s): _____

Preferred Pronouns: _____ Date: _____

Age: _____ Date of Birth: _____ Referred By: _____

Name of Parent(s) or Guardian (if applicable):_____

Address: _____

_____

Phone Number (Check box for preferred contact #):

- ☐ Home: _____
- ☐ Cell: _____
- ☐ Other: _____

Email: _____

Which phone number is the best number for me to contact you? _____

Additional phone numbers or numbers for Parent/Guardian(s) if applicable:

_____

_____

Note: Voice mail is the only contact I have available at this time that is considered to be HIPAA compliant. If you agree to text and email communication below, it is with the understanding that this information is potentially vulnerable to a violation of confidentiality if information is hacked.

Is it okay for me to leave a voice message?	Yes	No
Is it okay for me to leave a text message?	Yes	No
Is it okay for me to send an email message?	Yes	No
May the messages contain confidential information?	Yes	No

Emergency Contact Name and Phone Number: _____

Name of person responsible for payment, and contact information if not already listed above:

_____

Please list the people with whom you are living, their ages and relationship to you:

Name Age Relationship to you

Are you currently: ☐ Working? Occupation/Employer: _____
☐ In School? Interest or field of study: _____
☐ Other: _____

Do you currently have any medical or mental health diagnoses? If so, please describe:

Please list any relevant medications or supplements you are currently taking:

Do you have any special dietary concerns or restrictions? Yes No
If yes, please describe:

Do you currently work with any other professionals such as a psychotherapist, coach, speech therapist, occupational therapist, nutritionist, etc? Yes No

If yes, please indicate the name of the professional and their specialty:

Have you seen other professionals in the past for these issues? Yes No

If yes, please list their names, specialty, and the approximate dates of service:

Do you have any difficulties sleeping? Yes No If yes, please describe:

Do you drink alcohol? Yes No If so, how often? _____

Do you use recreational drugs? Yes No If so, how often? _____

Do you play video games? Yes No If so, how often? _____

What are you hoping to accomplish with therapy? _____

Have you already been working on any of these goals? If so, what have you tried? What worked or did not work?

Do you feel anxious about working on these goals? Please circle your level of anxiety where 1 = no anxiety, and 10 = the most anxiety you have ever experienced:

1 2 3 4 5 6 7 8 9 10

Please describe your strengths: _____

Please describe your interests or hobbies:

Is there anything else I should know in order to be more helpful to you?