April Wise, Psy.D., LMFT

CLIENT INTAKE QUESTIONNAIRE

DATE: _____

Name: _____ DOB (mm/dd/yy): _____ Age: _____

Address: _____ City/State: _____ Zip: _____

E-mail: _____ Alternate E-mail: _____

Please indicate the means by which you prefer to be contacted. You may check more than one:
Phone: ____ Text: ____ E-mail: ____ Regular Mail: ____. If you would prefer to be contacted at a phone number, e-mail, or address other than what is listed above, please provide that information here: _____

Gender:

Woman: ____ Man: ____ Transgender: ____ Transman: ____ Transwoman: ____ Gender Nonconforming: ____ Other: ____

Orientation:

Straight: ____ Gay: ____ Lesbian: ____ Bisexual: ____ Asexual: ____ Queer: ____ Questioning: ____ Other: ____ Prefer not to answer: ____

What type of services are you currently seeking? Please mark an "X" by the type of services you are seeking.

Individual therapy: ____ Marital/Couples therapy; Family therapy: ____ Group Therapy: ____ EMDR: ____ Unsure: ____

Other (describe): _____

Goals of Treatment:

What compelled you to seek therapy at this time?

_____
_____
_____

Describe your current concerns, issues, or problems that you hope to resolve:

_____
_____
_____

Relationship Status (Please check all that apply):

Are you presently married or involved in a relationship? Yes ____ No ____.
If you answered yes, how would you describe your current level of satisfaction with the relationship?

Source of Income:

Employment: ____ Unemployment: ____ Spouse/Significant Other: ____ Social Security: ____ Short Term-Disability: ____

Other: _____

Current Employment Status (Please check all that apply):

Working Full-Time: ____ Working Part-Time: ____ Retired: ____ On medical leave: ____ Unemployed and looking for work: ____
Not employed due to other reasons: ____ Full-Time Student: ____ Part-Time Student: ____

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Education Information: (Please check the highest level of education/degree you have received):

Elementary, Grades 1-8: ____ Some High School (no diploma): ____ High School Diploma/GED: ____ Some College (no degree): ____
Technical/Trade School Graduate: ____ Associate's Degree: ____ Bachelor's Degree: ____ Master's Degree: ____
Professional Graduate Degree (i.e., MD, JD, etc.): ____ Doctoral Degree (i.e., PhD, EdD, etc.): ____

Military History:

Currently on active duty: ____ Served in Military for: ____ number of weeks, months, or years (please select). Never served: ____
If you have served in the military were you ever deployed? Yes ____ No ____
If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:

_____
_____
_____
_____

Emergency Contact Information: (Who you prefer me to contact in case of an emergency)

Name: _____ Relationship: _____

Phone Number: _____ Email: _____

Referral Information:

Were you referred? Yes ____ No ____. If referred, by whom? _____

Payment Information:
If you are planning to use health insurance, please contact Headway.com to assist you in making arrangements. Otherwise, payment will be made by IVY-PAY, a secure HIPPA compliant credit card company.

Previous Mental Health Treatment History:

Have you participated in therapy? Yes ____ No ____. If YES, please complete the information below:

Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or
Other: _____ Phone Number: _____ Email: _____
Address: City/State: Zip:
Dates of treatment: _____ Focus of treatment: _____

Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or
Other: _____ Phone Number: _____ Email: _____
Address: City/State: Zip:
Dates of treatment: _____ Focus of treatment: _____

Have you ever been hospitalized because of a mental health disorder? Yes ____ No ____. If you indicated that you have been hospitalized for a mental health disorder, please complete the following information:
Reason for hospitalization: _____
Was hospitalization: Voluntary _____ or Involuntary _____ ? How long was your hospitalization? _____
Where were you hospitalized? _____
Course of treatment during hospitalization: _____

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Medical Treatment Information:

Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition? Yes ___ No ___.
If you currently have a medical condition, please provide the following information:

Current medical condition: _____ How long have you had the condition? _____
Is it a medically treatable condition? Yes ____ No ____. If, it is not a medically treatable condition (i.e., palliative care), please describe:

_____

_____

_____

If you are currently taking prescribed medications for the condition please describe the type of medication, indicate how long you have been taking the medication, and any side effects.
For example: *"High blood pressure medication (type of medication); 2 years (length of time on medication); Drowsiness (example of a side effect).*

_____

_____

_____

_____

Trauma History (Optional):

Have you been – or are you currently being – emotionally, physically, or sexually abused?
Yes ____ No ____ Prefer not to answer ____. If you checked "Yes," you may use the space below to describe the underlying circumstances:

_____

_____

_____

_____

Family of Origin Information (Optional):

Please provide the following information about your parents either (biological/adopted) or stepparent:

Name of Mother: _____ Name of Father: _____
Mother's occupation: _____ Father's Occupation: _____
Name of Stepmother: _____ Name of Stepfather: _____
Stepmother's Occupation: _____ Stepfather's Occupation: _____

Are either of your parents (biological or adopted, and/or step parents) deceased? If your parents are deceased, please provided the following information:

- Mother/Stepmother has been deceased for ____ days/weeks/months/years.
  What was your age at the time of your mother's/stepmother's passing? ____ Yrs
- Father/Stepfather has been deceased for ____ days/weeks/months/years years.
  What was your age at the time of your father's/stepfather's death? ____ Yrs

Which of the following statements most resonates with you:

- My parents were present during my *entire* childhood, yes or no? Yes: ____ No: ____. Explain:

_____

_____

_____

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- My parents were present during *a part* of my childhood, yes or no? Yes: ____ No: ____. Explain:

_____

_____

_____

- My parents were not present during my entire childhood, yes or no? Yes: ____ No: ____. Explain:

_____

_____

_____

Which of the following describes your childhood family experience:

It was: outstanding ____ normal ____ chaotic ____ home environment, or Prefer not to answer ____

Mental Health/Risk Assessment:

Please identify if you have experienced any of the following and whether this is a past, current, or reoccurring issue:

____ Suicidal Thoughts: Past: ____ Present: ____ Reoccurring: ____

____ Thoughts of wanting to intentionally harm myself: Past: ____ Present: ____ Reoccurring: ____

____ Thoughts of wanting to intentionally cause harm to someone else: Past: ____ Present: ____ Reoccurring: ____

____ Post-Traumatic Stress: Past: ____ Present: ____ Reoccurring: ____

If you are currently experiencing any thoughts of either harming yourself or someone else please answer the following questions:

How long have you had these thoughts? _____

How frequently do you have these thoughts? _____

_____ _____

Do you have a plan and/or the means to carry out either the threat of harm to yourself or to someone else, yes or no? Yes: ____ No: ____.
If yes, please explain: _____

_____

_____

Have you ever tried to harm yourself or anyone else in the past? Yes: ____ No: ____.
If yes, please explain: _____

_____

Alcohol/Substance Use History (Optional):

Family Alcohol Abuse History: To the best of your knowledge, please indicate which of the following family member(s) struggles or struggled with alcohol/substance abuse or addiction:

Father: ____ Mother: ____ Grandparent(s): ____ Sibling(s): ____ Stepparent(s): ____
Uncle(s)/Aunt(s):____ Spouse/Significant Other: ____ Children: ____

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Please indicate your substance use status:

No history of use: ____ Actively using alcohol or drugs: ____ In early full remission: ____ In early partial remission: ____
In sustained full remission: ____ In sustained partial remission: ____

If you indicated that you have an alcohol/substance abuse or addiction history, please identify the types of treatment you have participated in, or are currently participating in, and how long you have been participating in the particular treatment.

Outpatient treatment: _____
Inpatient treatment: _____
12-Step Program: _____
Stopped using on my own: _____
Other Method: _____
Was the above treatment method effective?
Please explain: _____
_____

Please identify the type(s) of substances you are using, how frequently you use the substance, and how long you have been using the substance, and your frequency of use (i.e., daily, as needed, no regulation of use, etc.)

____ Opioid(s) | Classification: _____	Length of use: _____	Frequency of use: _____
____ Heroin	Length of use: _____	Frequency of use: _____
____ Cigarettes/Tobacco	Length of use: _____	Frequency of use: _____
____ Alcohol	Length of use: _____	Frequency of use: _____
____ Amphetamines	Length of use: _____	Frequency of use: _____
____ Barbiturates	Length of use: _____	Frequency of use: _____
____ Cocaine	Length of use: _____	Frequency of use: _____
____ Crack	Length of use: _____	Frequency of use: _____
____ Hallucinogens	Length of use: _____	Frequency of use: _____
____ Inhalants	Length of use: _____	Frequency of use: _____
____ Marijuana	Length of use: _____	Frequency of use: _____
____ Other	Length of use: _____	Frequency of use: _____

If you have indicated that you have used, or are currently using substances, please indicate what side effects and or consequences you experienced or are experiencing as a result of the use.

Overdose: ____ Suicidal Impulse: ____ Depression: ____ Anxiety: ____ Blackouts: ____ Loss of control: ____ Medical conditions: ____
Other: ____ Please use the space provided to describe any other effects or consequences you have experienced:

_____
_____
_____
_____

Spiritual/Cultural History (Optional):

Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:

_____
_____
_____
_____

Do any of the above religious, cultural, or spiritual issues contribute either positively or negatively to your current well-being?

_____
_____
_____
_____

Additional Information

Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events:

_____
_____
_____
_____

Patient Signature: _____ Date: _____