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Intake Questionnaire

Name: _____ Date: _____

Address: _____

Phone: _____ Message May Be Left: ☐ Yes ☐ No

Email: _____

Date of Birth: _____ Religion/Spirituality: _____

Emergency Contact (EC) Name: _____

EC Phone: _____ EC Relationship to You: _____

Primary Care Physician (PCP) Name: _____

PCP Phone: _____ PCP Location: _____

Medication Currently Taking (*include dosage):* _____

_____

Symptoms/Concerns (*Please check all that apply):*

☐ Depressed Mood	☐ Panic Attacks	☐ Employment Issues	☐ Grief
☐ Stress	☐ Obsessions/Compulsions	☐ Eating Disorder	☐ Family Conflict
☐ Self Esteem	☐ Hallucination/Delusions	☐ Past Trauma	☐ Religious Issues
☐ Poor Concentration	☐ Phobias	☐ Sexual Abuse/Rape	☐ ADD/ADHD
☐ Low Energy	☐ Sexual Dysfunction	☐ Emotional Abuse	☐ School Issues
☐ Appetite Disturbance	☐ Relationship Issues	☐ Domestic Violence	☐ Self-Harm
☐ Mood Swings	☐ Hopelessness	☐ Past Substance Use	☐ Suicidal Thoughts
☐ Irritability/Anger	☐ Under or Over Sleeping	☐ Current Substance Use	☐ Homicidal Thoughts

Other Medical Issues: _____

Reasons for Seeking Therapy: _____

_____

How Did You Find My Therapy Practice? ☐ Google Search ☐ Psychology Today ☐ Good Therapy

☐ Referral By: _____ ☐ Other: _____