Intake Questionnaire

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First Name _____ Last Name _____ DOB ___/_____/____

Preferred Phone # (____) _____ - _____ Okay to leave voicemail message? **Y** **N**

Email:_____ Okay to email (scheduling purposes)? **Y** **N**

Street Address: _____ City: _____ Zip: _____

Health Insurance & Referral Information

Health Insurance Provider: _____ Member ID: _____

Group #: _____

Emergency Contact

1. Name: _____ Relationship to you: _____
   Phone: (____) _____ - _____

Wellness Information

Primary Care Physician Name: _____ Phone: (____) _____ - _____

Permission to Contact (if necessary for collaboration of care) **Y** **N**

Medications

Are you currently taking prescribed medications? **Y** **N** If yes, please list each medication and its purpose(s):

_____
_____
_____
_____

Have you been hospitalized within the last year? **Y** **N** If yes, please describe reason(s):

_____

Mental Health

Do you have a doctor prescribing you mental health medication(s)? **Y** **N**

Name of Prescriber: _____ Phone: (____) _____ - _____

Have you ever had a negative experience with counseling? **Y** **N**

Have you ever experienced suicidal thoughts? **Y** **N**

Are you currently experiencing suicidal thoughts? **Y** **N**

Have you ever attempted suicide? **Y** **N**

If yes, when:_____

Homicidal Thoughts? **Y** **N**

If yes, when:_____

Current Needs. Tell me what brings you here today.

_____

_____

_____

Client Signature: _____Date:_____/_____/_____