heartsandmindshealth
licensed mental health services in DC and NOVA

Client Intake Questionnaire

The information that you provide in this questionnaire will be helpful in planning services for you. Please answer each item carefully and ask for clarification if necessary.

Full Name:_____ Age _____ Date:_____

Address:_____

_____

Telephone: cell: _____ work:_____ home:_____

e-mail address:_____
Any restrictions to contact via e-mail/phone numbers provided?:_____

Date of Birth:_____ Marital Status: _____ # of Children:_____

How were you referred?_____

Please list the primary concerns that led you to seek help at this time:

What are your goals for treatment?

Please list any major illnesses, hospitalizations, surgeries, injuries, and current major health concerns as well as the date of your last examination by a physician:
Exam Date: ____/____/____

Please list any medications you are now taking, the dosage, and the reason for their use:

Have you ever received psychiatric help or counseling before? (circle) YES NO
If yes, please state when, where, and with whom:

Please check all of the following items that concern or pertain to you:

	Nervousness		Shyness		Depression		Fears
	Anxiety		Stomach Problems		Concentration		Self-Control
	Sexual Abuse		Physical Abuse		Emotional Abuse		Career Choices
	Fatigue		Relaxation		Energy Level		Avoidance
	Alcohol Use		Drug Use		Appetite/Eating		Sadness
	Sleeping A Lot		Trouble Sleeping		Flashbacks		Nightmares
	Suicidal Thoughts		Panic Attacks		Ambition		Inferiority Feelings
	Relationships		Sexual Problems		Dissatisfaction		Marriage/Partner
	Separation/Divorce		Hyperactivity		Mood Swings		Parenting
	Forgetfulness		Frequent Lying		Money Management		Aggression
	Perfectionism		Self-Criticism		Headaches		Anger
	Decision-Making		Body Image		Sexual Identity		Self-Injury

_____ Difficulty coping with a loss (please specify_____)

_____ Difficulty coping with a medical diagnosis (please specify _____)

Please add any additional information you feel would be useful:

Please list all members of your current household:

Name Age Relationship

Family History:

Describe the family you grew up with and your impressions about your parents/caregivers' relationship:

List siblings, age difference, and relationship (ex: Ann - sister, 5 yrs older, strained):

Work History:

Occupation:_____ How long? _____

Are you satisfied with your present employment? YES NO Highest education level:_____

Please add any other information regarding your quality of life at work or home that you feel would be useful.

Spirituality:

What religious or spiritual upbringing did you have?

What role does spirituality or religious faith play in your life today?

Sexual History:

I identify as (check one) ___heterosexual ___homosexual ___bisexual ___other: _____

What sexual problems or concerns have you experienced?

Overall, how would you describe your sex life?

What traumatic sexual experiences have you had?

Chemical Use History:

Describe your use of alcohol, drugs, prescription medication, or other substances including amount and frequency of use:

Have there been any negative consequences from your use? Please explain:

Has anyone expressed concern regarding your use? Please explain:

Are you concerned about any other compulsive or addictive behavior? Please describe:

Please add any additional information that you feel may be useful in our work together:

_____

_____

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_____

Thank you for completing this questionnaire.

_____ _____

Your Signature Date

OFFICE USE

Diagnostic notes: