INTAKE FORM / NEW CLIENT QUESTIONNAIRE

Welcome to Intralogy Psychotherapy! Thank you for taking a few minutes to fill out this form. The information you provide is confidential, and will be helpful for you and your counselor when you meet for the first time. If you have any questions, just ask!

Today's Date_____

Name _____Age ____Date of Birth _____/_____/____

Adress

_____

street city state zip

Phone (Primary) _____ (Secondary)_____

Okay to leave a
message? Y___ N___

Email (please print clearly) __

Okay to send an email regarding an appointment and/or to reschedule? Y___ N___

Ethnicity_____Where did you grow up_____

Highest Education Achieved _____ Occupation _____

What is your religious and/or spiritual background / involvement / interest?

_____

Emergency contact person (name, relationship, phone, address).

_____

Closest Relationships (please list name, birth date, relationship, and whether they live with you)

Name	Birth Date	Relationship	Living with you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current living arrangement (Do you live with others?)

_____

Have you participated in any therapy or counseling before? Y___N___

If yes, when _____

Reson_____

Are you currently seeing a psychiatrist, therapist, or helper? Y____ N___ If yes, please provide name and contact information here

_____

Have you or a family member ever been hospitalized for mental or emotional illness? Y_____ N_____
If yes, please explain—dates, where, reason:

_____

_____

Substance abuse / addiction history? Yes _____ (please explain) No _____

_____

_____

Legal History (arrests, prison, DWI, parking tickets?)

_____

_____

Medical Information: Doctor's name and phone

_____

Name Contact Information - phone

Are you on any medications? Y___N___ If so, what and why were they prescribed?

_____

_____

How can we help? Please tell us in your own words what brings you here today?

_____

_____

_____

_____

What are your 2 most important goals for therapy?

1.

_____

2._____

Common problem/symptom checklist. Fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe.

___marriage	___divorce/separation	___alcohol/drugs	____God/faith/spirituality
___pre-marital	___child custody	___other addictions	___infertility
___being single	___disabled	___grief/loss	___past hurts
___sexual issues	___work/career	___depression	____codependency
___family	___school/learning	___fear/anxiety	____intimacy
___children	___money/budgeting	___anger control	___communication
___parents	___aging/dependency	___loneliness	___self-esteem
___in-laws	___weight contro	___mood swings	___stress management

Family Information:

Marital Status (check any that apply): Single ___ Dating ___ Committed relationship ___ Engaged ___

Married ___ (how long? _____) Separated ___ (how long? _____) Divorced ___ (how long?_____)

Spouse's Name (if applicable) _____ Age _____ Occupation _____

I would describe my friendships as: Close ___ Somewhat close____ Distant____ Conflicted____

I would describe my relationship with my mother as: Close ___ Somewhat close____ Distant____ Conflicted____

I would describe my relationship with my father as: Close ___ Somewhat close____ Distant____ Conflicted____

How many siblings do you have? _____ How would you describe your relationship?
_____

Crisis Information: Are you having any current suicidal thoughts, feelings or actions? Y_____ N_____
If yes, explain _____

Any current homicidal or violent thoughts or feelings, or anger-control problems? Y_____ N_____
If yes, explain _____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y_____ N_____
If yes, describe
_____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y____ N____
If yes, describe _____

In difficult times, who and/or what are you likely to turn to for support?
_____

Who referred you to us?
_____

THANK YOU for taking the time to fill out this information sheet BEFORE your first meeting. This will be reviewed with you during your first counseling session.