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New Client Intake Questionnaire

Please fill out **completely**

Name of Client: _____ Today's Date: ___/____/____ DOB: ___/____/____

What Gender Does Client Identify As: _____ Pronouns: _____

Gender Assigned at Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Additional Address: _____ City: _____ State: ____ Zip: _____

Home phone: (____)_____ Client's cell: (____)_____

Client email: _____ Parent/Guardian Email: _____

Parent/Guardian's Cell: (____)_____ Other Parent/Guardian's Cell: (____)_____

Emergency Contact's Name: _____ Phone: (____)_____

Relationship to Emergency Contact: _____

If client is under the age of 13:

Name of Parent/s or Legal Guardian/s: _____

- **ALLERGIES:** _____

REQUIRED: In cases of parents being separated or divorced, a copy of the parenting plan that states who has medical decision-making rights must be attached.

FAMILY
Who currently lives in your residence (adults & children):

#	Name	Age	Relationship	What gender do they identify as:
1				
2				
3				

In case of an emergency call 911 or go to your local ER/ED
In case of a crisis call: 988, (King Co) 1-866-427-4747, (Snohomish Co) 1-800-584-3578,
National Suicide line 1-800-273-8255

4				
5				
6				
7				

Additional family members you feel close to:

Pets? Tell me about them:

Why are you coming to counseling? Please be specific:

What has you deciding to come to counseling right now?

How long has this been going on? When did this start?

What do you hope to gain from counseling?

SYMPTOMS

Please check all symptoms or experiences you have had and how recently:

X	Symptom / For How Long	X	Symptom / For How Long
	Difficulty falling asleep		Difficulty staying asleep
	Difficulty getting out of bed		Frequent waking during the night
	Sleeping too much		Not feeling rested after waking

Average hours of sleep per night: _____

X	Symptom / For How Long	X	Symptom / For How Long
	Loss of interest in previously enjoyed activities		Spending increased time alone
	Withdrawing from people, places, activities		Feeling numb
	Depressed mood		Irritability / cranky
	Feeling of worthlessness		Anger outburst / meltdowns
	Rapid mood changes		Worthlessness
X	Symptom / For How Long	X	Symptom / For How Long
	Frequent feelings of sadness		Panic attacks

Client Name: DOB: Today's Date:

	Anxiety, extra stress / worries		Frequent feelings of guilt
	Anxiety attacks		Difficulty leaving your home
	Repetitive behaviors or thoughts		Difficulty with transitions
	Fear of certain things or situations		Feeling or acting like a different person
	Changes in eating or appetite		Eating significantly less
	Eating markedly more		Use of laxatives
	Voluntary vomiting		Binge eating
	Excessive exercising		Trying to lose weight? Yes [ ] No [ ]
	Recent weight gain		Recent weight loss
	Difficulty catching your breath		Increased muscle tension
	Unusual sweating		Easily startled
	Decreased energy		Heart palpitations
	Racing thoughts		Difficulty concentrating / focusing
	Large gaps in memory		Flashbacks
	Difficulty problem solving		Difficulty following through with tasks
	Out of ordinary dependency on others		Difficulty soothing or self-regulating
	Concerns about your sexuality		Gender concerns
	Bullying or being bullied		

	Feelings as if you were outside of yourself, detached, observing what you are doing? Explain:
	Intrusive thoughts, impulses, or visions? Explain:
	See things that others cannot see? Explain:
	Hear things other cannot hear? Explain:
	Feeling that your thoughts are controlled pr placed in your mind? Explain:

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	Feeling that the TV, gaming system, or music is communicating with you? Explain:
	Sensory issues/concerns. Please specify:

Other symptoms or experiences, not mentioned above, that you have are experiencing? Please explain:

TREATMENT INFO

What are your current stressors?

What do you like most about yourself?

What are your strengths?

What are your goals for therapy? Be specific.

1)

2)

3)

More or other goals:

MEDICAL

Primary Doctor: Clinic name: Last time you saw Dr:

Dr. phone: ( ) Fax: ( )

Have you ever seen a counselor, therapist, psychologist, psychiatrist, or other mental health professional? Yes [ ] No [ ]. If "yes" please fill out the following in detail.

Name of professional:	Name of professional:
Dates of treatment. Month: Yr: Phone: ( ) Fax: ( ) Reason for seeking help: Formal Diagnoses/is:	Dates of treatment. Month: Yr: Phone: ( ) Fax: ( ) Reason for seeking help: Formal Diagnoses/is:

Client Name: DOB: Today's Date:

Have you undergone psychological or neuro-psychological testing? Yes [ ] No [ ]. If "yes", please explain:

Practitioners name & phone #:	Dates:	Type of testing done:

Are you currently taking any PRESCRIBED medication/s: Yes [ ] No [ ] If "yes", please explain:

Medication name:	Dose & time of day	Prescriber's name & phone #

Add additional pages if needed.

Supplements or non-prescription? Yes [ ] No [ ]. If "yes", please explain:

Name of supplement/other:	Dose:	Frequency:

What about your family's medical history? Anyone have serious, diagnosed, chronic, or hereditary conditions that may be beneficial for me to know?

Any family history of mental illness in your family and extended family? Yes [ ] No [ ]. See below.

FIRST name only:	Age:	Relation to you:	Mental illness / diagnoses/is:

Client Name: DOB: Today's Date:

Anyone in your family or extended family attempt to kill themselves? Yes [ ] No [ ]. If "yes", please explain:

Have you had any serious injuries or medical diagnoses? Such as seizures [ ], head injuries [ ], neuro(brain) injuries or surgeries [ ], any surgeries [ ], unexplained falls [ ], gastrointestinal issues [ ], pregnancy [ ], other [ ]. Please explain details:

Have you had, or is there any history of alcohol, drug, use or abuse?
Me: Yes [ ] No [ ] Other family: Yes [ ] No [ ] . If "yes" to either, please explain below:

FIRST name only:	Age/s when using:	Relation to you:	Alcohol or name drug/s:

Have you had any Occupational Therapy or Physical Therapy or Energy work? Yes [ ] No [ ]. If "yes", please explain:

OT / when:	PT / when:	Energy work / when:	Other / when:

ABOUT YOU

- What can you tell me about your birth story? [ ] I was adopted & don't know. [ ] I don't know information about my birth.
- How long was your parent pregnant with you? _____ months. Were there any complications?

Client Name: DOB: Today's Date:

Yes [ ] No [ ]. If "yes", please explain:

- Your delivery: Normal [ ] Breech [ ] Cesarean [ ] Other [ ] (Please explain):

- Your development. At what age did you: Walk _____ Talk _____ Potty train _____ Read _____

- Were you breast [ ] or bottle fed [ ]. If breast, for how long?

- Have you ever experienced abuse? None [ ] Domestic [ ] Emotional [ ] Sexual [ ] Physical [ ] If "yes", to any, was it reported to the police? Yes [ ] No]]. If "yes", date it was reported: ____/____/_____. Please explain what, when (your age or the year):

Was it reported to Child Protective Services? Yes [ ] No [ ]. If "yes", date it was reported: ____/____/_____. Please explain what, when (your age or the year):

- School name: Current grade:

- Learning accommodations? None [ ], 504 [ ] , IEP [ ], other [ ], please explain:

- Employment: For how long?

- Spiritual or religious affiliation/s:

- Hobbies, interests, sports, activities, groups:

Safety

Have you ever hurt yourself? Yes [ ] No [ ] . If "yes", please explain. How recently: How often: Method:

Do you currently have any plans to hurt yourself? Yes [ ] No [ ]. If "yes", please describe:

Have you ever attempted to kill yourself? Yes [ ] No [ ]. If "yes", Please describe when and what happened below:

Do you have access to guns or other weapons? Yes [ ] No [ ]. If "yes", please explain:

Do you have any thoughts or plans to hurt of kill another person? Yes [ ] No [ ]. If "yes", please share who? When? Where? How/method?

ADDITIONAL

Other information you think would/might be helpful for me to know:

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♦Have you attached any custody or parenting legal forms?♦

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