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**Intake Questionnaire**

Today’s date (month/day/year): \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_

Full name (first, middle, last):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_ Preferred name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Home phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to contact?  Yes  No OK to leave message?  Yes  No

Cell phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to contact?  Yes  No OK to leave message?  Yes  No

Work phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to contact?  Yes  No OK to leave message?  Yes  No

Email address (for scheduling related inquiries only):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Employer and/or School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_Male \_\_\_Female \_\_\_Transgender

Relationship status:

\_\_\_Single \_\_\_Civil union, domestic partnership, or equivalent

\_\_\_Serious dating or committed relationship \_\_\_Divorced

\_\_\_Living together \_\_\_Separated

\_\_\_Married \_\_\_Widowed

Race/ethnicity:

\_\_\_African-American/Black/African \_\_\_European American/White/Caucasian

\_\_\_American Indian or Alaskan Native \_\_\_Hispanic/Latino/Latina

\_\_\_Arab American/Arab \_\_\_Persian

\_\_\_Asian American/Asian \_\_\_Multiracial (please specify):

\_\_\_East Indian \_\_\_Other (please specify):

Country of origin:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_ Are you a US citizen or permanent resident?  Yes  No

Sexual orientation:

\_\_\_Heterosexual \_\_\_Bisexual

\_\_\_Gay \_\_\_Questioning

\_\_\_Lesbian \_\_\_Prefer not to answer

Religious or spiritual preference(s):

\_\_\_Agnostic \_\_\_Christian \_\_\_Earth-based, Pagan

\_\_\_Atheist \_\_\_Hindu \_\_\_No preference

\_\_\_Buddhist \_\_\_Jewish \_\_\_Prefer not to answer

\_\_\_Confucian \_\_\_Muslim \_\_\_Other:

Describe, if you wish:

Do you have a diagnosed and documented disability?

\_\_\_Attention Deficit/Hyperactivity \_\_\_Physical/Health-related Disorders

\_\_\_Deaf or Hard of Hearing \_\_\_Psychological Disorder/Condition

\_\_\_Learning Disorders \_\_\_Visual Impairments

\_\_\_Mobility Impairments \_\_\_Other (please specify):

\_\_\_Neurological Disorders

Have you been or are you currently enlisted in any branch of US military (active duty, veteran, National Guard, reserves)?  Yes  No

Did your military experiences include any traumatic or highly stressful experiences that continue to bother you)?  Yes  No

Your physician or clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any health problems for which you currently receive treatment or significant past health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any prescription or non-prescription drugs you are now taking and how often (for example: Valium, alcohol, antihistamines, cigarettes, coffee):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever received psychiatric or psychological help or counseling of any kind?  Yes  No

If yes, please explain when, where, with whom, and the reason(s):

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Have you ever been hospitalized for mental health reasons?  Yes  No

If yes, please explain when, where, with whom, and the reason(s):

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NAME AGE RELATIONSHIP TO YOU OCCUPATION

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Briefly describe your reason(s) for seeking help. Please identify any situations for which you are particularly seeking assistance.

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Describe the ways that your concerns currently interfere with your personal and/or professional life. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What have you already tried to do about your concern(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please provide any additional information you feel may be useful. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list an emergency contact person:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about my practice?

\_\_\_Referred by (please indicate):

\_\_\_Website (please specify):

\_\_\_Other (please specify):

Please **circle** all of the following issues or problems that pertain to you.

Stress Eating patterns Purpose in life Romantic relationship issues

Relaxation Restricting eating Fitting in Marriage

Nervousness Binge eating Friends Sepration/Divorce

Anxiety Vomiting Loneliness Parenting

Fears Purging Relationships Children

Racing thoughts Excessive exercising Shyness Parents

Chest pains Use of diet pills Physical contact Adoption

Muscle tension Weight Shame Sexual problems

Headaches Depression Abuse Gender issues

Dizziness Unhappiness Unwanted sexual contact Sexual orientation issues

Nervous tics Sleep Problems Dissociation Infertility

Palpitations Appetite Nightmares Pregnancy

Excessive sweating Self worth Hurting self Pregnancy Loss

Excessive thirst Tiredness Risk taking behavior Religious/spiritual issues

Phobic avoidance Boredom Attention deficit Cultural issues

Hypochondriasis Motivation Excitement seeking Physical disability

Obsessive thoughts Memory Drug/Alcohol use Learning disability

Compulsions Concentration Self control Education

Rituals Guilt Anger Finances

Bowel troubles Decision making Aggressive behavior Work/Career choices

Stomach trouble Energy Temper outbursts Ambition

Health problems Irritability Jealous feelings Avoidance

Pain Over-focused Loss of control Legal matters

Menstrual problems Inferiority feelings Suspicious of others My thoughts/beliefs

Sexually transmitted disease(s) Suicidal thoughts Homicidal thoughts Feeling unreal

Hearing problems Suicidal plans Homicidal plans Odd behavior

Visual disturbance Suicidal behaviors Homicidal behaviors Hearing things

Delusions Unusual experiences Hallucinations Other: