DEMOGRAPHIC INFORMATION & INTAKE QUESTIONNAIRE

Please fill out this questionnaire to the best of your ability. You are not obligated to share any information you do not wish to share, but honest information will help the counselor best address your needs.

____ ________________ ________-______-__________

Client's Full Name (First, M.I., Last) DOB (MM/DD/YYYY) Social Security Number

Address: ____ City/State/ZIP: _____________________________

Cell Phone: ____________________ Other Phone: ___________________ Email:___________________________

Gender: ______________ Race: _____________________ Relationship Status: ____________________________

If client is under 18:

_____________________________ ______________ ____

Guardian's Name *Guardian DOB* *Who does the child live with? Note any custody details.*

Appointment Reminders (check all that you wish to receive): ▢ Voice ▢ Text ▢ Email

Communication Preferences: ▢ Phone Calls ▢ Email (not secure; scheduling only) ▢ Text Messages

Who recommended counseling? ________________________ **How did you find out about us?** ________________

What is your main reason for seeking counseling at this time? ____

____

Any Previous Counseling or Mental Health Treatment? ▢ None ▢ I Don't Remember ▢ Yes (please fill out):

Name and Location (of clinic, doctor, counselor, etc.)	**Type of Treatment** (example: counseling, inpatient, group, IOP, medications)	**Approximate Dates or Ages**	**Reason for treatment, or diagnosis** (example: depression, suicidal thoughts, family problems, anger, etc)

Office Use Only - Insurance Information

___________________________ ___________________________ ____________________ ______________

Primary Insurance Company Name *Client ID# or Policy ID#* *Insured's Name & DOB* *If Applicable: Group #*

___________________________ ___________________________ ____________________ ______________

Secondary Insurance (if applicable) *Client ID# or Policy ID#* *Insured's Name & DOB* *If Applicable: Group #*

What are your coping skills (what helps you feel better)? ____

What makes you feel worse (or "triggers" your problem)?____

Medical History

Who is your primary doctor? ______________________________________ ▢ I need a referral for a primary doctor

Please list any health problems or past surgeries: ____

Please list any allergies (medications, food, environmental): ____

What medications are you currently using?

Medication Name	Dose (mg, mcg)	Time Taken	Purpose	Prescribed By

Previous medications? ____

Briefly describe your eating and exercise habits: ____

Substance Use History

Have you ever tried any of the following substances (non-prescribed)? (check all that apply)

Name of Substance	Dates or Ages of use	How much / how often?	Any resulting problems?
▢ Alcohol			
▢ Marijuana			
▢ Heroin			
▢ Opioids/Pain killers			
▢ Cocaine or crack			
▢ Hallucinogens			
▢ Other: _____________			

Have you ever received help for drug/alcohol abuse? ▢ No ▢ Yes

If yes, when and where? ____

Do you smoke cigarettes? ▢ No ▢ Yes If yes, how many per day? __________ Any interest in quitting? ▢ Yes ▢ No

Present Situation

Do you practice spirituality or religion? ▢ Yes ▢ No If yes, what is your religion/belief system? ________________

Do you have a partner or spouse? ▢ Yes ▢ No If yes, how long have you been together? _________________

How is your relationship with your partner? ____

Any previous significant relationships? ▢ Yes ▢ No If yes, list approximate begin/end dates:

____

Any abuse or violence in previous or current relationships? ▢ No ▢ Yes - current ▢ Yes - past (when:__________)

If current, do you feel unsafe? _________ Do you need assistance with domestic violence services? __________

Are you sexually active? ▢ Yes ▢ No What is your sexual orientation? ________________________________

Are you currently pregnant? ▢N/A ▢ No ▢ Yes (Due Date: __________) Number of prior pregnancies: __________

Do you have child(ren)? ▢ Yes ▢ No If yes, please describe:

Child's Name	Gender	Age	Other Parent's Name	Lives With	How is your Relationship?

Any current or past involvement with DCF? ▢ None ▢ Past, as a child ▢ Past, as a parent ▢ Currently involved

If current, briefly describe reason: ____

If current, name and city of DCF worker: ____

Have you ever been arrested? ▢ Yes ▢ No Do you have any current legal problems? ▢ No ▢ Yes

Are you probation or parole? ▢ No ▢ Yes If yes, who is your PO? ______________________________________

Family History

Who raised you? ____

Where did you grow up? ____

How was your childhood? ____

Were you adopted or in foster care? ▢ Yes ▢ No

If yes, at what ages? ____

Are your parents: ☐ Still together ☐Separated/Divorced ☐ Father deceased ☐Mother deceased

(If separated or deceased, how old were you? ____)

If parents are not together, briefly describe parents' subsequent relationships, step-parents/step-siblings, etc:

Father's side: ____

Mother's side: ____

Describe your relationship with your mother: ____

Describe your relationship with your father: ____

Siblings and their ages: ____

Family members' medical conditions: ____

Family members' mental health conditions: ____

Have you experienced any physical, emotional, or sexual abuse in your lifetime? ☐ Yes ☐ No ☐ Prefer not to say

____

Educational/Occupational History

Highest level of school completed? ____________ What are/were your topics of study? ____________

How was school for you? ____

Have you struggled with learning disabilities or developmental delays/problems? ☐ No ☐Yes: ____________

Current Work Situation : ☐ Full-time ☐ Part-time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

What has been your past/present occupation? ____

If disabled, do you receive any benefits or assistance (SSI, SSDI, SAGA, etc)? ☐ No ☐Yes: ____________

Are you currently applying for disability benefits? ☐ No ☐Yes

Additional Information Anything else you want the counselor to know?

____

____

Client Signature: ______________________________ Date: ____________

Thank you for completing this assessment.