Barbara Howell, LMFT

New Client Questionaire for Individuals

Date: _____

Name (Last, Middle Initial, First):

_____

Street Address: _____ City: _____

State: _____ Zip: _____

Home phone: _____ Alternate phone: _____ E-mail: _____

Alternate E-mail: _____

Please indicate the means by which you prefer to be contacted. You may check more than one: Phone: ____ Text: ____ Email: ____ Regular Mail: ____.

If you would prefer to be contacted at a phone number, e-mail, or address other than what is listed above, please provide that information here:

_____

Date of Birth: _____ Age:_____

Gender identity:

Woman: ___ Man: ___ Transgender: ___ Transman: ___ Transwoman: ___ Gender-Nonconforming: ___ Other: ___

Orientation: Straight: ___ Gay: ___ Lesbian: ___ Bisexual: ___ Asexual: ___ Queer: ___ Questioning: ___ Other: _____ Prefer not to state: ____

Relationship status: _____

Source of Income: Employment: ___ Unemployment: ___ Spouse/Significant Other: ____

Social Security: ____ Short Term-Disability: ____ Other: ____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone number: _____ Email: _____

Referral Information: Were you referred? Yes: _____ No: _____ If referred, by whom?

_____

Payment Information: Please indicate how you intend to pay for treatment:

Cash: ___ Check: ___ Credit Card: ____ Insurance: _____ Third-Party: _____.

If you are planning to use health insurance, please provide the following information:

Name of Insurance Company: _____

Subscriber's Name: _____

Insured's ID number: _____ Group Policy Number: _____

Co-Payment Amount: _____

Insurance Claim's Mailing Address: _____

Telephone number: _____

Previous Mental Health Treatment History:

Have you participated in therapy in the past? Yes: _____ No: ____

If YES, please complete the information below:

Name and type of provider (Psychiatrist, Psychologist, Therapist, or Other):

_____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Dates of treatment: _____

Focus of treatment: _____

Name: _____

Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____

Phone Number: _____ Email: _____

Street Address: _____City: _____ State: _____

Dates of treatment: _____

Name and type of Provider (Psychiatrist, Psychologist, Therapist, or Other):

_____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Dates of treatment: _____

Focus of treatment: _____

Have you ever been hospitalized because of a mental health issue? Yes: _____ No: _____

If yes, please describe the reason for hospitalization:

_____

_____

_____

_____

How long was your hospitalization?

_____

Where were you hospitalized?

_____

What treatment did you receive during hospitalization?

_____

_____

Please provide the name of the providers who treated you below and indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Licensed Therapist):

Name: _____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Dates of treatment: _____

Name: _____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Dates of treatment: _____

Name: _____

Phone Number: _____ Email: _____ Street Address: _____ City: _____ State: _____

Dates of treatment: _____ Current Mental Health Treatment: Are you currently participating in therapy or counseling? Yes: ____ No: _____

If YES, please complete the following information:

Name of Current Provider: _____

Type of provider: _____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Dates of Treatment: _____

Focus of Treatment: _____

Name of Current Provider: _____

Type of Provider: _____

Phone Number: _____Email: _____

Street Address: _____ City: _____ State: _____

Dates of Treatment: _____

Focus of Treatment: _____

If you are currently receiving therapeutic services from another psychotherapist, to avoid a duplication of services, it may be necessary for me to contact your current psychotherapist to coordinate care. You may be required to sign and "Authorization for Release of Confidential Information" form which will be provided to you and maintained as part of your clinical record along with a copy of this patient intake form.

* Please Initial: _____

If you are currently under the care of a psychiatrist, are you taking any prescribed psychiatric medication(s), yes or no? Yes _____ No_____.

If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects in the space below. For example: "Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)." _____
_____
_____
_____
_____
_____
_____
_____

Medical Treatment Information:

Are you currently receiving treatment for a serious or chronic medical condition?

Yes: _____ No: _____

If you currently have a medical condition, please provide the following information:

Current medical condition: _____

How long have you had the condition? _____

If you are currently taking prescribed medications for the condition please describe the type of medication, indicate how long you have been taking the medication, and any side-effects you have experienced.

_____
_____
_____
_____
_____

Describe your current concerns, issues, or problems that you hope to resolve: (Feel free to attach additional pages, as needed.)

_____
_____
_____
_____
_____
_____
_____
_____

Do you have specific goals for therapy?

_____
_____
_____
_____
_____

Additional Information Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events (Feel free to attach extra pages, as needed):

_____
_____ _____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

For in-person intake:

Working Full-Time: _____ Working Part-Time: _____ Retired: _____ On medical leave: _____Unemployed and looking for work: _____ Not employed due to other reasons ____

Full-Time Student: _____ Part-Time Student:_____

Education Information: (Please check the highest level of education/degree you have received): Elementary, Grades 1-8: _____ Some High School (no diploma): _____ High School Diploma/GED: _____ Some College (no degree): _____

Technical/Trade School Graduate: _____Associate's Degree: _____ Bachelor's Degree: _____ Master's Degree: _____ Professional Graduate Degree (i.e., MD, JD, etc.):_____ Doctoral Degree (i.e., PhD, EdD, etc.):_____

Military History:

Currently on active duty: _____ Served in Military (please circle length of time served) for: _____ number of weeks, months, or years. Never served in the military: _____

If you have served in the military were you ever deployed, yes or no? Yes: _____ No: ____. If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:

_____
_____
_____
_____

Legal History:

Have you been ordered by the court to participate in this therapy, yes or no? Yes: ____ No: ____If yes, you may be required to supply supporting documentation such as a copy of the court order. Are you currently involved in any kind of litigation or legal dispute, yes or no? Yes: _____ No: _____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):

_____
_____
_____

Family of Origin Information (Optional):

Were you adopted? Yes: _____ No: _____.

If you were adopted, how old were you at the time? _____

If you were adopted, do you have a relationship with your birth mother and/or father?

Yes: _____ No: _____

If yes, please describe the nature of the relationship. For example, explain how the relationship with your biological parent(s) was established, how old you were at the time the relationship began, the frequency of contact you had or currently have, and the nature of the relationship:

_____

_____
_____
_____
_____
_____

If you were adopted, what type of relationship do you/did you have with your adopted parents?

_____
_____
_____
_____
_____

If you were not adopted, what type of relationship do you/did you have with your biological parents?

_____
_____
_____
_____
_____

Please provide the following information about your parents either (biological/adopted) or stepparent:

Name of Mother: _____ Mother's occupation: _____

Name of Father: _____ Father's Occupation: _____

Name of Stepmother: _____ Stepmother's Occupation:_____

Name of Stepfather: _____ Stepfather's Occupation: _____

Are either of your parents (biological or adopted, and/or step parents) deceased?

If your parents are deceased, please provided the following information:

Mother/Stepmother has been deceased for _____ days/weeks/months/years.

How old were you at the time of your mother's/stepmother's passing? _____ Father/Stepfather has been deceased for _____ days/weeks/months/years.

How old were you at the time of your father's/stepfather's passing? _____

Do you have any biological siblings, adopted siblings, step siblings, or half siblings?

Yes: ____ No: ____ If you have siblings, how many? _____

In the space provided below, list the name and ages of each of your siblings and briefly describe the nature of your relationship as being "close," or "not close," or "estranged," or any other word that describes the nature and extent of your relationship with your siblings.

_____
_____
_____
_____

_____
_____
_____
_____

Which of the following statements most resonates with you:

My parents were present during my entire childhood? Yes: _____No: _____.

Please explain: _____
_____
_____
_____

My parents were present during some of my childhood, yes or no? Yes: ____ No: ____

Please explain: _____
_____
_____
_____

My parents were not present at all during my childhood? Yes: ____ No: ____

Please explain: _____
_____
_____
_____

Which of the following describes your childhood family experience:

It was an outstanding home environment. _____ It was a normal home environment. _____

It was a chaotic home environment. _____ I prefer not to answer. _____

If you indicated that your home environment was chaotic, please explain.

_____
_____
_____
_____
_____
_____

Please identify if you have experienced any of the following and whether this is a past, current, or reoccurring issue:

____ Suicidal Thoughts: Past:_____ Present: _____ Reoccurring: _____

_____Thoughts of wanting to intentionally harm myself: Past: _____ Present: _____ Reoccurring: _____

_____ Thoughts of wanting to intentionally cause harm to someone else: Past: _____

Present: _____ Reoccurring: _____

_____ Post-Traumatic Stress: Past:_____ Present: _____ Reoccurring: _____

If you are currently experiencing any thoughts of either harming yourself or someone else please answer the following questions:

How long have you had these thoughts?

_____

How frequently do you have these thoughts?

_____

_____

_____

Do you have a plan and/or the means to carry out either the threat of harm to yourself or to someone else, yes or no? Yes: _____ No: _____If yes, please explain:

_____

_____

_____

Have you ever tried to harm yourself or anyone else in the past, yes or no? Yes: ____ No: ____If yes, please explain:

_____

_____

_____ Is there anything that would stop, or prevent, you from harming yourself or someone else, yes or no? Yes: ____ No: ____ If yes, please explain?

_____

_____

_____ If you indicated that there is not anything that would prevent you from harming yourself or someone else, please identify how likely it is that you might actually harm yourself or someone else: Imminently likely: _____ OR Not at all likely: _____ Alcohol/Substance Use History (Optional): Family Alcohol Abuse History: To the best of your knowledge, please indicate which of the following family member(s) struggles or struggled with alcohol/substance abuse or addiction: Father: ___ Mother: ____ Grandparent(s): ____ Sibling(s): _____ Stepparent(s): _____ Uncle(s)/Aunt(s):____ Spouse/Significant Other: _____ Children: _____ SAMPLE 76 The Therapist | July/August 2017 | www.camft.org how well do you know your patient? Please indicate your substance use status: No history of use: _____ Actively using alcohol or drugs: ____ In early full remission: ____ In early partial remission: _____In sustained full remission: _____ In sustained partial remission: _____ If you indicated that you have an alcohol/ substance abuse or addiction history, please identify the types of treatment you have participated in, or are currently participating in, and how long you have been participating in the particular treatment. Outpatient treatment:

_____ Inpatient treatment:

_____ 12-Step Program: _____

Stopped using on my own:

_____ Other

Method: _____
Was the above treatment method effective? Please explain:
_____
_____ Please identify the type(s) of substances you are using, how frequently you use the substance, and how long you have been using the substance, and your frequency of use (i.e., daily, as needed, no regulation of use, etc.) Opioid(s): ____ Classification: ____ Length of use: _____ Frequency of use: _____ Heroin: ____ Length of use: _____ Frequency of use: _____ Cigarettes/Tobacco: ___ Length of use: _____ Frequency of use: _____ Alcohol: ____ Length of use: _____ Frequency of use: _____ Amphetamines: ____ Length of use: _____Frequency of use: _____ Barbiturates: ____Length of use: _____ Frequency of use: _____ Cocaine: ___ Length of use: _____ Frequency of use: _____ Crack: _____ Length of use: ___ Frequency of use: _____ SAMPLE (888) 89-CAMFT | July/August 2017 | The Therapist 77 how well do you know your patient? Hallucinogens: _____ Length of use: ____ Frequency of use: _____ Inhalants: _____ Length of use: ____Frequency of use: _____ Marijuana: _____ Length of use: ____ Frequency of use: _____ Other: _____ Length of use: ____ Frequency of use: _____ If you have indicated that you have used, or are currently using substances, please indicate what side effects and or consequences you experienced or are experiencing as a result of the use. Overdose: _____ Suicidal Impulse: _____ Depression: _____ Anxiety: _____ Blackouts: _____ Loss of control: _____ Medical conditions: _____Other: _____ Please use the space provided to describe any other effects or consequences you have experienced:
_____
_____
_____
Spiritual/Cultural History (Optional): Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:
_____
_____
_____ Do any of the above religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? If so, please describe:
_____
_____
_____