Client Intake Questionnaire

Full Name: _____ Date: _____

Address: _____

_____

Telephone Numbers: Home: _____ Okay to call: Yes ___ No ____

Work: _____ Okay to call: Yes ___ No ____

Cell: _____ Okay to call: Yes ___ No ____

Email address: _____

Is it ok to contact you through email? Yes___ No___

Gender: Male ____ Female ____ Date of Birth: _____ Age: _____

Social Security #_____

Marital Status: Single ____ Married ____ Separated ____ Divorced ____

Remarried ____ Widowed ____ Co-Habiting ____ Other _____

Occupation/Employer (if couple, please list each spouse's employer separately):

_____

_____

Please check highest educational level: Grade School ____ Middle School ____

High School ____ Some College ____ Bachelor's Degree ____

Master's Degree ____ Doctorate ____ Area(s) of study:

_____

_____

Religious Preference (if any):_____

Person to contact in case of emergency: _____

Address: _____

Phone: _____ Relationship: _____

Marital History (if never married, skip this section)

1st Marriage Beginning Date: _____ Ending Date (if applicable): _____

Name of Spouse: _____

Children & Ages: _____

_____

2nd Marriage Beginning Date: _____ Ending Date (if applicable): _____

Name of Spouse: _____

Children & Ages: _____

_____

Please list the names & ages of all people currently living in your home.

Name	**Age/Birth Date**	**Relationship**

Who has custody of the minor children living in your home? _____

Medical History

Overall rating of physical health: Excellent Good Fair Poor

Date of last physical exam: _____

Name of Physician: _____ Phone: _____

Current Medical Conditions: _____

_____

_____

History of Medical Conditions: _____

_____

_____

History of Medical Hospitalizations: _____

_____

_____

Please list name, dosage & length of time you have been taking any medications for physical conditions: _____

_____

_____

_____

History of Chemical Dependency Treatment

Treatment Issue/Type of Treatment: _____

Treatment Dates: _____

Treatment Provider: _____

Mental Health History

Are you currently under the care of a psychiatrist? Yes ____ No ____

Name of psychiatrist: _____ Phone: _____

Please list name, dosage & length of time you have been taking any psychotropic medications: _____

_____

_____

Have you ever consulted a professional counselor before? Yes ____ No ____

Name of therapist: _____ Phone: _____

Dates: _____

Are you currently in therapy elsewhere? Yes ____ No ____

Is there mental illness in your family history? Yes____ No____

If yes, please describe _____

_____

_____

For what general areas of your life (marital, family, school, work, substance abuse, grief, etc.) are you seeking assistance today?

Area 1: _____

Area 2: _____

Area 3: _____

For each area you identified, what changes/improvements will be signs of progress?

Area 1: _____

Area 2: _____

Area 3: _____

What do you hope to accomplish today? _____

_____

Circle any of the following that are presently causing you difficulty.

Assertiveness	Alcohol Use	Career Choices	Self-Concept
Parenting	Sexual Problems	Legal Matters	Religion
Nightmares	Loneliness	Marriage	Separation
Bed-Wetting	Energy	Concentration	Suicidal Thoughts
Nervousness	Parents	My Thoughts	Decision Making
Anxiety	Relaxation	Ambition	Education
Divorce	Depression	Shyness	Stress
Temper	Friends	Dating	Memory
Inferiority	School	Unhappiness	Finances
Drug Use	Confusion	Tiredness	Fears
Appetite	Sadness	Pre-marital	Food
Work	In-Laws	Abuse	My Past
Guilt	Anger	Trust	Relationships

Please review the items you circled and put an asterisk* by the **3** areas that are causing you the **most** difficulty at this time.

Please provide any additional information that you think may be useful to your therapist.

_____

_____

_____

_____

_____

_____

_____

FEE POLICY:

The fee for counseling services is set at $125 per 50 minute session

I request that cancellation be made 24 hours in advance; otherwise, you will be financially responsible for the session.

Other services such as court appearances, inpatient visits, or significant telephone counseling, etc. are based on the session rate in addition to transportation expenses. Payment for service is expected at the time of each service. Your health insurance may provide reimbursement for professional psychological services. I encourage you to consult your policy for specifics with regard to "out-of-network providers". Please note that clients who choose to file insurance are still expected to pay the full fee for services at each visit.

CONFIDENTIALITY:

The State of Tennessee provides that client information is confidential and will not be shared without your written consent unless required by the following three statutes:

• Any suspected child or elder abuse is required to be reported to the appropriate governmental authorities.

• If there is reason to believe that the client is in imminent danger to him/herself or to any other individuals, I am required by law to report this to the appropriated authorities as well as to warn any individuals who may be threatened.

• When a client is involved in legal proceedings, client records may be subpoenaed.

PROFESSIONAL SERVICES:

I am available for counseling appointments at selected times throughout the weekday with limited evening appointments.

You may leave a voice mail message at my office number (615-373-7175) at anytime and I will receive the message at my earliest convenience. If you are unable to reach me and you have an emergency, please call the Crisis Line at 615-244-7444 or go to your local emergency room.

BENEFITS AND RISKS OF COUNSELING:

Persons contemplating counseling should realize that they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives, etc. They may change employment or other aspects of their lives. While I will assist the client in effecting change, I cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.

CREDENTIALS:
I hold an M.A. degree in Counseling from Trevecca University and am licensed in Tennessee as a Professional Counselor with Mental Health Service Provider designation.

Do you have any questions about fees, confidentiality or other matters? Yes____ No____
Do you agree to the conditions and provisions of the Practice Policies? Yes____ No____

Signature: _____Date:_____

Signature: _____Date:_____