

CLIENT INTAKE QUESTIONNAIRE

Tiffany F. Spahn, MA, CADCI

Name: _____ Today's Date: _____ First Middle Last
Age: _____ Birth Date: _____

Address: _____ City, State, Zip: _____

Telephone(s): _____
(home) (mobile) (work)

E-mail 1: _____ e-mail 2: _____

May I leave messages for you?

on home or mobile phone on work phone on email other _____ No

I live alone Others living in the home Significant others outside the home

Name:	Name:	Name:	Name:
Age:	Age:	Age:	Age:
Relationship:	Relationship:	Relationship:	Relationship:

Emergency contact: _____ Phone: _____ Relationship: _____

Please let me know how you were referred to me: _____

	Education	Occupation	Employer
Self			
Partner			

STRENGTHS & ISSUES

Why are you seeking counseling at this time?

When did you start having these issues?

What is going well in your life?

Hobbies & Interests?

How are your family relationships (current family and family of origin)?

Do you have any health issues or injuries?

What are your goals for this visit?

Is there any other information that may be helpful (for example, issues of diversity, spirituality or significant recent events)?

Check any of the following that you are experiencing:

Depression		Change in sleeping habits	
Feeling hopeless		Memory problems	
Extreme sadness		Lack of energy	
Feeling tearful		Change in eating habits	
Trouble concentrating		Weight changes	
Feeling of extreme happiness		Change in sexual interest or function	
Trouble performing your job		Problems getting along with friends or family	
Lack of enjoyment of usual activities		Feeling stressed	
Self-esteem problems		Easily irritated	
Perfectionism		Feeling guilty	
Feeling fearful		Feeling nervous	
Physical complaints of pain		Sudden feelings of panic	
Problems with anger		Muscle tension	
Thoughts of hurting yourself or others		Acting violently	
Concern regarding drug or alcohol use		Thoughts of killing yourself or others	
Domestic Violence		Past or current physical or sexual abuse	
Problems with partner or spouse		Verbal abuse as a child	

HAVE YOU EVER BEEN IN COUNSELING BEFORE?Yes No

If you have been in counseling before, please describe it below. Start with the most recent time first.

A. Date(s):	
Provider Name:	
What was this experience like?	

B. Date(s):	
Provider Name:	
What was this experience like?	

MEDICAL INFORMATION

Have you seen a doctor within the last year?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Why have you seen a doctor?		
Who is your doctor?		
Location:		Phone:
Are you taking any medications, prescription or over-the-counter?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please describe:		
Medications	Dosages	
1.		
2.		
3.		
4.		
5.		

SUBSTANCE USE HISTORY

Do you use/ have you used tobacco (any form)?	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do you use/ have you used alcohol	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do you use/ have you used caffeine (any form, including cola drinks)	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do you use/ have you used other mind-altering substances (drugs)?	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe:			
1.	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
2.	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
3.	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
4.	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>

IF THERE IS OTHER INFORMATION THAT YOU THINK IS IMPORTANT, PLEASE USE THE SPACE BELOW.
THANK YOU FOR FILLING OUT THIS FORM.