



Intake Questionnaire

Account Information

Name: (Last) _____ (First) _____ (Middle) _____

Address: (Street) _____

(City) _____ (State) _____ (Zip) _____

Referred By: _____ Date of Birth: (dd/mm/year) _____

Phone: (H) _____ (W) _____ (Mobile) _____ (Fax) _____

Where should we leave a message? Home ____ Work ____ Mobile ____

Name of Insurer: _____

Policy holder (if not yourself): _____

Policy ID No. _____ Group/Contract No.: _____

Claims Address: _____

Authorization No., if pre-authorized: _____

Provider Customer Service No. _____

I have read and reviewed the HIPAA privacy statement and the New Client Information brochure, have copies of both, understand the information given and agree to the terms and conditions stated for purposes of receiving mental health services at Northland Therapy Center. I realize that I will be charged for cancellations less than 24 hours in advance and that I am responsible for any amounts not covered by insurance.

Client Signature

Parent or Guardian (only if needed)

Witness

Intake Date:

Current Problems

What concerns made you consider therapy? _____

Why now? _____

What is your best understanding of the problem? _____

What symptoms are troubling you? _____

What goals do you have for therapy? _____

How long do you expect to remain in therapy? _____

Please describe any previous counseling or therapy (with whom, how long, what you worked on): _____

In your previous counseling/therapy experiences, what worked and what didn't? _____

Medical Information

Primary Physician: _____

Address: _____

Phone: _____

May we have permission to consult with your physician if needed? Yes No

Please list any current or past medical problems or significant illnesses:

Please list medications you are now taking, prescriptions, over the counter, homeopathic, Ayurvedic supplements: _____

Please describe how you get exercise and how you deal with stress: _____

Have you ever been in the hospital or taken medicine for an emotional problem? _____

Has anyone in your family ever been hospitalized or taken medicine for an emotional problem? _____

Please describe your current use of alcohol or any other mood altering substance or non-substance addictions (e.g. food, sex, internet):

Have you ever been treated for a problem with alcohol, substances or non-substance addictions? _____

Has anyone in your family had a problem with their use of alcohol, substances or non-substance addictions? _____

Education and Employment

Current Job/Occupation: _____

Years of Formal Education: _____ Schools, Academic Degrees & Majors:

What is your purpose/work in this life? _____

Relationships

Relationship status: Single ___ Coupled ___ Separated ___ Divorced ___

Celebrate ___ Widowed ___ In a Significant Relationship _____

If coupled, please list partner's name, address and phone: _____

If in a relationship, please describe it: _____

Please indicate your degree of satisfaction with these relationship dimensions (0=total dissatisfaction, 10=total satisfaction):

Emotional Intimacy:	0	1	2	3	4	5	6	7	8	9	10
Financial Intimacy:	0	1	2	3	4	5	6	7	8	9	10
Sexual Intimacy:	0	1	2	3	4	5	6	7	8	9	10
Extended Family:	0	1	2	3	4	5	6	7	8	9	10
Division of Labor:	0	1	2	3	4	5	6	7	8	9	10
Parenting:	0	1	2	3	4	5	6	7	8	9	10

Please list the members of your family of origin:

Name	Sex	Age	Married? Y or N	Role in Family	Occupation

Please list the members of your current family or those with whom you live:

Name	Sex	Age	Role in Family	Occupation

Please describe any information about your family, current or past, that might be helpful, for example, moves, deaths, job losses, separations or divorces, re-marriages, or any kind of abuse:

In what religious tradition were you raised? _____
How would you describe your spirituality or religious commitment now?
