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Licensed Marriage and Family Therapist (#MFC52419) • Licensed Professional Clinical Counselor (#LPC420)
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Client Intake Questionnaire

Date: _____

General

Name: _____

Address: _____

_____

_____

Cell phone: _____ ❑ Voicemail OK?

Home phone: _____ ❑ Voicemail OK?

Email: _____ ❑ OK to email?

Names and ages of children (if any):

_____

_____

_____

Date of birth: _____

Marital status: _____

Ethnicity: _____

Educational level: _____

Occupation: _____

❑ Full-time ❑ Part-time

Emergency contact:

Name: _____

Phone number: _____

Relationship to you: _____

Who lives in your home with you right now?

Name/Age	Relationship to you

How did you find me?

❑ Personal referral from: (Name) _____

May I thank them for the referral? ❑Yes ❑No

❑ My website (www.rbpcounseling.com) How did you find my website? _____

❑ Another website: (Name) _____

❑ Other: _____

Financial Information

Annual household income _____ Do you own or rent? _____

Which payment method do you plan to use for your sessions? ❑ Check ❑ Credit card ❑ Cash

Areas of Concern

What issues/concerns cause you to seek treatment? _____

_____

_____

Do you have any specific goals with regard to your treatment? _____

_____

Do you have any particular concerns/fears with regard to treatment? _____

_____

Medical History

Name & Type of Current Physician (general practitioner, OB/GYN, etc.):

_____

Phone Number: _____

❑ OK for me to contact doctor? (I will have you sign a release before contacting)

Please list any prescription medications you are currently taking.

Medication	For how long?	Prescribed by whom?

Please describe your overall health today. Do you have any medical conditions that may affect your mental health treatment? _____

_____

Have you ever been diagnosed with a serious illness? Please describe. _____

_____

_____

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____ On average, how much alcohol do you consume in a week?

_____

Do you currently, or have you ever used recreational or illegal drugs? _____

Please describe your use. _____

_____

Have you ever been in a 12-step or other substance abuse program? _____

Please describe. _____

_____

Psychological History

Are you currently having any suicidal thoughts? Please describe. _____

_____

Have you ever attempted suicide? _____ If so, when? _____

Please describe the circumstances that led to that attempt. _____

_____

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Name of treating therapist(s) _____

Please list any medications you have taken, or are taking, for a mental or emotional condition.

Medication	When & for how long?	Prescribed by whom?

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies. _____

_____

Please feel free to include any other additional information that you believe is relevant to your mental health treatment. _____

_____

_____

_____

_____

_____

_____