ASJ Family Counseling Center Inc.

Patient Intake Questionnaire II

To be completed after initial session and acceptance as a Client

Please print out this form and enter information in ink and bring to second session

A General

Name: _____

B. Financial Information:

Annual household income _____ Do you own or rent? _____

How do you intend to pay for treatment? __ cash __ check __ charge __ insurance

If planning to use health insurance:

C. Name of Insurance Company

_____

Policy number _____ Group number _____

Telephone number _____

D. Areas of Concern:

What issues/concerns causes you to seek treatment? Please describe.

_____

_____

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

E. Psychological History:

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment?

_____

Name of treating therapist(s), address(es), telephone number(s)

_____

Authorization for release of confidential information will be needed so that any former therapist may be contacted.

Signature: _____

Have you ever been subjected to one or more psychological tests? _____

If so, by whom?

Name of person(s) administered psychological tests, address(es), telephone number(s)

_____

_____

Authorization for release of confidential information will be needed so that any test administrator may be contacted.

Signature: _____

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long?

_____

Why were you hospitalized?

_____

Name of treating therapist, address, telephone number

_____

Authorization for release of confidential information will be needed so that any former therapists may be contacted.

Signature: _____

Are you currently taking any prescription medications? _____

Prescribed by whom? _____

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long? _____

Authorization for release of confidential information will be needed so that health care provider may be contacted.

Signature:_____

Have you ever attempted suicide? _____

When? _____

Describe the circumstances that led to that attempt.

_____

_____

_____

Are you currently having any suicidal thoughts? Please describe

_____

_____

Please describe your childhood

_____.

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

_____

_____

_____

Have you ever been a victim of a violent crime? Please describe

_____

_____

_____

F. Medical History:

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

_____

_____

_____

Do you have any medical conditions that may affect your mental health treatment?

Yes: ___ No: ___

Please describe your overall health today.

_____

_____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe.

_____

_____

Have you ever been in a 12-step program? 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 use illegal drugs? Please describe your use

_____

_____

Have you ever used illegal drugs? Please describe.

_____

_____

_____

G. Family of Origin History:

Mother's name: _____ age: _____

living: ___ deceased: ___ patient's age at the time of mother's death: _____

description of relationship with mother.

_____

_____

Father's name: _____ age: _____

living: ___ deceased: ___ patient's age at the time of father's death: _____

description of relationship with father.

_____

_____

Names and ages of siblings: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

H. Other Information:

Please describe your spiritual identity/orientation:

_____

Please describe your interests/hobbies:

_____

_____

Are you now or have you ever been involved in a lawsuit? _____

Please describe:.

_____

_____

_____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.

_____

_____

_____