Valerie Andersen, Psy.D.
Licensed Psychologist | PY9730
Certified Accelerated Resolution Therapist (ART)

Confidential Intake Questionnaire

Please complete the following information so that I can more fully understand your concerns.

Name: _____Date of Birth: _____ Age: _____

Phone number: _____ Email Address: _____

Address:

_____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Phone: _____

Emergency contact's relationship to you:

_____

I am here for: *(circle)* Evaluation / Testing Therapy / Counseling

Gender: _____ Racial / Ethnic Background: _____

Sexual Orientation: _____ Religious Background: _____

Relationship Status: *(circle one)* Single Married Separated Divorced Widowed

How long has this been your relationship status? _____

If in a relationship, are you satisfied? *(circle one)* Yes / No / I don't know

Do you feel supported by your partner / spouse? *(circle one)* Yes / No / I don't know

How many people can you count on for emotional support and friendship? _____

Please list any family members currently living with you, their occupation, and age:

_____

_____

_____

Including yourself, please list any family members who have had significant emotional, mental health, or addiction problems:

_____

_____

_____

Who in your family do you feel closest to? _____

Most distant from? _____

In most conflict with? _____

What is your highest level of education: _____ Are you a student? *(circle one)* Yes / No

Did you / do you receive exceptional student education (ESE) services? *(circle one)* Yes / No

Do you have any disabilities?

_____

Are you currently working? *(circle one)* Yes / No If no, when did you last work?

_____

Occupation(s):

_____

At which office location are you interested in receiving therapy?

Clearwater / Riverview / Virtual / In-office and Virtual (mix)

Will you be utilizing Insurance / Self-Pay to cover cost of therapy services? If Insurance, what company? _____

How did you arrive for your appointment today?

_____

How did you find me? / Who referred you?

_____

If a referral, may I thank them? *(circle one)* Yes / No

What is your primary problem / concern at this time?

_____

_____

_____

How would you rate the intensity of this problem or concern? *(circle one)*

1	*2*	*3*	*4*	*5*
Not at all		*moderate intensity*		*extreme intensity*

How have you tried to cope with your problem / concern so far?

_____

_____

How motivated are you to resolve this problem now? *(circle one)*

not at all	a little	somewhat	moderately	extremely

What physical / medical problems do you have now?

_____

_____

_____

Please list any current medications:

_____

Physician who prescribed medication: _____

Do you have any concerns about sexual functioning? *(circle)* Yes / No

How many times per week do you exercise? _____

For how long each time? _____

Please list any previous medical concerns:

_____

_____

_____

Do you smoke? *(circle)* Yes / No

If yes, how often, how many per day? _____

Do you drink alcohol? *(circle)* Yes / No

If yes, how often, how many drinks per week? _____

Have you ever "blacked out", not remembered doing something, or gotten somewhere without knowing how you got there? *(circle)* Yes / No

If yes, please describe:

_____

_____

Do you / have you used any illegal drugs? *(circle)* Yes / No

If yes, which drugs do you / did you use? *(circle)* Marijuana / Cocaine / LSD / Heroin / Opiates / other: _____

How often do you use? _____

Do you, or does someone else think you need to cut down, or stop using drugs or drinking? *(circle)* Yes / No

Have you noticed any recent changes in your weight? *(circle)* Increase / Decrease / No change

Have you noticed any recent changes in your appetite? *(circle)* Increase / Decrease / No change

Have you received mental health treatment with a psychologist, psychiatrist , or counselor in the past? *(circle)* Yes / No

If yes, what were your concerns? _____

_____

Are you working with a mental health clinician now? *(circle)* Yes / No

If yes, with whom? _____

Have you ever been hospitalized for mental health concerns? *(circle)* Yes / No

If yes, when and for how long?

_____

_____

Are you currently having suicidal thoughts? *(circle)* Yes / No If yes, how many times per week? _____

Have you had suicidal thoughts in the past? *(circle)* Yes / No If yes, how many times?

_____

Are you currently thinking of harming others? *(circle)* Yes / No If yes, how often?

_____

Have you thought of harming others in the past? *(circle)* Yes / No If yes, how many times?

_____

Have you ever intentionally harmed yourself? *(circle)* Yes / No If yes, when?

_____

Have you ever attempted suicide? *(circle)* Yes / No If yes, when? _____

Have you ever had a head injury or loss of consciousness? *(circle)* Yes / No

Do you have a history of seizures? *(circle)* Yes / No

Have you ever had a stroke or head injury? *(circle)* Yes / No

Have you ever experienced a traumatic event or loss? *(circle)* Yes / No

If yes, please describe:

_____

_____

Have you experienced any form of abuse? *(circle)* Y / N

Please circle all that apply: None Sexual Physical Verbal

If Yes, at what age(s) did the abuse occur? _____

Are you currently, or do you consider yourself likely to be involved in litigation in the near future? *(circle)* Yes / No

Are you currently, or have you previously served in the military? *(circle)* Yes / No

If yes, please specify the dates of service, and discharge:

_____

Is there some other information that would help me understand you, and / or your concerns?

If so, please include that information here:

_____

_____

_____

I verify that the above information is accurate, to the best of my knowledge:

Client Signature _____ Date _____