Empowered Hearts Therapy, LLC

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INTAKE QUESTIONAIRE

HISTORY

Name: _____ DOB: _____ Age: _____

Gender: ☐ Male ☐ Female Grade: _____ Occupation: _____

Phone: (home) _____ (cell) _____

Address: _____

Referred by: ☐ Relative ☐ Doctor ☐ Friend ☐ EAP ☐ Web Search

☐ Social Services ☐ Court Order ☐ Other: _____

Race/Ethnicity: _____

Marital Status: ☐ Single ☐ Married ☐ Cohabitating ☐ Separated ☐ Divorced

Number of years married/cohabitating: _____

Spouse's/Partner's name and phone numbers: _____

Name and ages of children: _____

EMERGENCY CONTACT

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you—perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else. Please write down the name and contact information for your emergency contact person.

Name: _____ Relationship to you: _____

Phone Number: _____ Address: _____

BACKGROUND

Main problem/major reason for seeking help at this time: _____
_____
_____

How have you had these problems, symptoms, or issues? _____

Have you had treatment for these issues in the past? ☐ Yes ☐ No

If yes, was the outcome helpful? ☐ Yes ☐ No

Have you had inpatient mental health treatment? ☐ Yes ☐ No

Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:
_____
_____

Have you had substance abuse treatment? ☐ Yes ☐ No

Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:
_____
_____

Do you have a family history of mental illness or substance abuse? If so, please explain._____
_____

Describe any other behavioral or emotional problems you are having: _____
_____

Describe the impact this has on your family/relationship/work: _____
_____

Describe your strengths and unique qualities: _____
_____

Are you currently under the care of a physician or psychiatrist? ☐ Yes ☐ No

If yes: Doctor's Name: _____ Phone # _____

Treatment for: _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list: _____

Do you have a history of abuse (physical, sexual, emotional, neglect)? ☐ Yes ☐ No

If yes, please describe briefly (if you feel comfortable doing so):

_____

SYMPTOM CHECKLIST Please check any of the following you have experienced:

Behavior	Current	Past	Behavior	Current	Past
Crying, sadness, depression			Temper outbursts		
Loss of enjoyment of usual activities			Irritability, anger		
Desire to die			Argues a lot		
Easily distracted			Disobedience		
Has Threatened/attempted suicide			Hallucinations		
Worries more than others			Unusual fears or phobias		
Panics			Anxious, nervous		
Repeats Unnecessary act over and over			Is overly concerned about things		
Has rituals, habits, superstitions			Twitches or unusual movements		
Eats very little/fasts to lose weight			Gorges or binge eats		
Sleepwalking			Blames others for own mistakes		
Withdrawn			Easily annoyed by others		
Nightmares, night terrors			Low motivation		
Low self-esteem			Disorientation		
Wakes up very early			Vomits intentionally		
Tiredness, fatigue			Injures self		
Restless sleep, wakes frequently			Having a lack of friends		
Trouble going to sleep			Feeling shy around others		
Sleeps too much			Grief or loss		
Poor appetite			Feelings of worthlessness		
Under or over weight			Chronic pain		
Over-activity			Drug use		
Frequently acts without thinking			Alcohol use		
Doesn't finish things			Cigarette use		
Headaches			Sexual problems		
Short attention span			Mood swings		
Academic concerns			Ideas of harming others		
Worries about money			Disorganized thoughts		
Concerned about family members			Problems at work		
Relationship problems			Feelings of hopelessness		
Daydreams, fantasizes			Problems with the law		

Please add any other information that would be helpful: _____

_____

Family Stresses Check all that apply:

	Current	Past		Current	Past
Marital Problems			Housing problems		
Marital Separation			Legal issues		
Divorce			Death of friend		
Custody disputes			Death of relative		
Financial problems			Death of pet		
Job loss			Family illness		
Partner using alcohol/drugs			Other: _____		

Please explain any selected above: _____

Medical History Indicate if you have had any of the following:

Condition	Yes	No	Age	Details
Serious infection				
Convulsions/seizures				
Head injuries				
Other injuries				
Hospitalizations				
Surgeries				
Poisonings				
Allergies				
Asthma				
Alcoholism				
Drug Use				
Sexual problems				

Family Information: List all of the people who currently live with you:

Name	Age	Relationship	Occupation/grade in school

What are your supports? (church, friends, clubs etc.) _____

_____

Indicate if any family members or relatives have the following:

	Mother		Father		Brother		Sister		Other	
Problem:	Now	Past	Now	Past	Now	Past	Now	Past	Now	Past
Problems with attention, activity or impulse control as a child										
Learning disabilities										
Did not graduate from high school										
Alcohol abuse										
Drug use										
Problems with aggressive behavior as adult or child										
Antisocial behavior (arrests, jail, legal problems, probation, other)										
Abuse victim										
Abusive to others										
Depression										
Nervous Disorders										
Intellectual disability										
Serious illness or surgeries										
Physical handicaps										
Tics or unusual movements										
Other mental health problems										

What are your strengths? _____

_____

_____

What are your goals for treatment? _____

_____

_____ _____ _____

Print name **Signature** **Date**