NANCY S. RICHARD, PH.D.
Clinical Psychologist

895 State Farm Road, Suite 210
Boone, NC 28607
(828) 266-9690

# INTAKE QUESTIONNAIRE

Name: ______________________________________ Age: ______ DOB: ________________
Marital Status: ___________________ Gender: M F Race: _________________________
Home Address: _________________________________________________________________
_______________________________________________________________________________
Cell Phone: ____________________ Email Address: _____________________________________
School or Occupation: ___________________________ Grade or Position: _______________________________
Place of Employment: _____________________________ Work Phone: __________________
May I call you at these phone numbers? Y N
Who referred you to me? _____________________________________________
Name of Person to contact in case of emergency:
____________________________________________ Phone: ______________________
Explain your reason for seeking psychotherapy:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

## CURRENT HOUSEHOLD

List the members of your family and all others in your home:

| Names | Age/Birth Date | Relationship | Occupation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please circle the problems which pertain to the client:

| | | |
|---|---|---|
| Family History | Depression | Fears |
| Nervousness | Sexual Problems | Suicidal Thoughts |
| Shyness | Divorce | Finances |
| Separation | Alcohol Use | Friends |
| Drug Use | Self-Control | Work/Job |
| Anger | Stress | Being a Parent |
| Sleep | Headaches | Ambition |
| Legal Matters | Memory | Making Decisions |
| Energy | Inferiority Feelings | Concentration |
| Loneliness | Career Choices | Health Problems |
| Education | Nightmares | Marriage |
| Children | Appetite | My Thoughts |

Other(s) : ____________________________________________________________

If you have consulted mental health professionals/facilities (i.e., hospitals, treatment centers, etc.) in the past, name them below (approximate times will be helpful):

Person/Facility Name: Treatment Dates:

1. ____________________________________________ ____________ to ____________

2. ____________________________________________ ____________ to ____________

3. ____________________________________________ ____________ to ____________

How has the problem(s) affected you and significant others (i.e., family, friends)?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

What do you expect as the eventual outcome (your goal) from psychotherapy?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

FAMILY HISTORY

With reference to your personal family and family of origin, check all that apply:

Issue | Explanation

( ) Alcoholism ______________________________________________________
( ) Drug Abuse ______________________________________________________
( ) Prescription Drug Abuse ______________________________________________________
( ) Emotional Abuse ______________________________________________________
( ) Child Neglect ______________________________________________________
( ) Verbal Harshness ______________________________________________________
( ) Sexual Abuse ______________________________________________________
( ) Workaholic ______________________________________________________
( ) Arrest ______________________________________________________
( ) Mental Illness ______________________________________________________
( ) Family Violence ______________________________________________________
( ) Other Stressor ______________________________________________________

Do you regularly drink alcohol (once per week)? Yes ( ) No ( )
If so, describe (type, frequency, and years of use): ____________________________________
______________________________________________________________________________
______________________________________________________________________________

Do you regularly use tobacco? Yes ( ) No ( )
If so, describe (type, frequency, and years of use): ____________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you experienced problems related to alcohol use, or health concerns due to tobacco use? Yes ( ) No ( )
If so, describe: _____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Are you currently a participant in a self-help group or program? Yes ( ) No ( )
If so, describe (frequency and duration of attendance): _______________________________
______________________________________________________________________________
______________________________________________________________________________

## HEALTH

Physician: ___________________________________________
Psychiatrist: ___________________________________________

Current Medications (list all prescription drugs)

| Medication | Dosage | Reason |
|---|---|---|

1.
2.
3.
4.

Over the counter (OTC) medications (list all OTC medications taken regularly):

1.
2.
3.
4.

Please describe all major health concerns: ______________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

## SOCIAL/PERSONAL

Religious Involvement: ______________________________________________________
_________________________________________________________________________
Church or Synagogue which you attend: _____________________________________________
Please describe your religious upbringing: _________________________________________
_________________________________________________________________________
Please describe any spiritual goals you have for counseling: ___________________________
_________________________________________________________________________
_________________________________________________________________________
How many biological children _____ stepchildren _____ foster children _____ or adoptive children _____ do you have? (Place number in blank).

Please include any data or history that you feel I should know about or ask you about in the first interview: ______________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________