Intake Questionnaire

This questionnaire will help your therapist understand your situation. If you feel uncomfortable answering any of the questions, you may leave them blank and discuss them when you meet with your therapist.

Name: _____ **Date:** _____

Home Address:

_____

Street Address City State Zip Code

Phone: Home _____ Cell _____

Email: _____ (*optional*)

Please check preferred method of contact: Home_____ Cell_____ E-mail_____

Local Emergency Contact: Name: _____Phone: _____

Relationship: _____

Referral Source: How did you come to seek services at the Oakland Cognitive Behavior Therapy Center? (Check all that apply)

_____ Internet

_____ Health professional: Name _____

_____ Other (please specify)_____

Reimbursement: If you would like to receive a monthly statement that you can forward to your insurance company to request reimbursement, please provide the e-mail address you would like us to use: _____

Personal Information

1. Age: _____ 2. Date of birth: _____ 3. Sexual Orientation: _____

4. Gender: How do you identify? _____ What are your pronouns?_____

5. Race/Ethnicity (check all that apply):

White _____ Black/African-American _____ Hispanic/Latino _____ South Asian _____

Middle Eastern _____ East Asian _____ Southeast Asian _____ American Indian/ Alaska Native _____

Pacific Islander _____ Other: _____

6. Current Religious Practices: _____

7. Marital status (check all that apply):

Single, never married ____ Cohabiting ____ Married ____ Widowed ____ Divorced ____ Separated ____

8. Please describe your current romantic/sexual relationships: _____

_____

_____

9. If you are divorced, when did you divorce? _____

10. If you are widowed, when and how did your spouse die? _____

11. If applicable, please list names and ages of your children:

Name	Gender	Age	Occupation

12. Number of persons living in your home and your relationships with them

_____

Family/Social History

1. Mother

Biological parent? Yes _____ No _____ Her occupation_____

Where was she born? _____

If living, age and health status _____

If deceased, year and cause of death _____

2. Father

Biological parent? Yes _____ No _____ His occupation _____

Where was he born? _____

If living, age and health status _____

If deceased, year and cause of death _____

3. Did your parents marry? Yes _____ No_____

4. Did your parents separate or divorce? Yes _____ No_____ If yes, when? _____

5. With whom did you primarily live while growing up?

Both Parents _____ Mother _____ Father _____ Other (please specify)

_____

6. Siblings

Name	Gender	Age	Occupation	Biological?
				Y / N
				Y / N
				Y / N

7. Where were you born? _____ 8. Where did you grow up? _____

9. Is English your first language? Yes _____ No_____ If no, please specify first language _____

10. If no longer living with your parents, at what age did you move out of your parents' home? _____

11. **Before the age of 16**, to what degree did you experience the following?

	None	Slight	Mild	Moderate	Severe
A chaotic home environment (e.g., frequent fighting, minimal structure, etc.)	0	1	2	3	4
Emotional reactions from your primary caregiver(s) that did not match the severity of what happened (e.g., extreme anger to a small mistake or minimal reaction to an abusive or harsh situation)	0	1	2	3	4
Emotional neglect, meaning your problems and experiences were ignored, and you felt that there was no attention or support from your primary caregiver	0	1	2	3	4
Psychological abuse at home (yelled at, falsely punished, subordinated to your siblings, or blackmailed)	0	1	2	3	4
Physical abuse (hit, kicked, beaten up or other types of physical abuse)	0	1	2	3	4
You were bullied, socially ostracized or had difficulties making friends	0	1	2	3	4
You were disciplined or reprimanded by teachers, including sent home, or suspended from school, etc.	0	1	2	3	4
You missed a lot of school	0	1	2	3	4
Financial hardship or strain	0	1	2	3	4

Any other details about your childhood or adolescence you'd like to share:

_____

Education and Employment History

1. Are you going to school now? Yes _____ No_____ Full-time_____ Part-time _____

If yes, where are you going to school? _____

2. Number of years of education completed _____ (*Please count 1st grade as the 1st year, so if you completed 4 years of high school that is 12 years, completed 4 years of college is 16, etc.)*

3. Where did you earn your highest degree? _____

4. Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations)?

Yes _____ No_____ If yes, give details: _____

5. Are you working now? (circle one): Yes _____ No_____

If Yes, many hours per week do you work? _____ Your occupation: _____

If No, what was the last job you held: _____

6. Are you receiving or have you applied for medical leave or disability benefits? Yes _____ No_____

7. Have you ever received medical or disability benefits? Yes _____ No_____

If yes, give details: _____

Current Problems and Treatment History

1. Please describe briefly the problem(s) that brought you in to see a therapist.

_____

_____

_____

a. When did you start having these problems? _____

b. Have you ever had problems like this before? Yes _____ No_____

c. If yes, when? _____

2. Are you currently seeing another mental health professional? Yes _____ No_____ If yes, indicate:

Provider's name _____ Date treatment began_____

3. Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy?

Yes _____ No_____ If yes, please provide the following information:

Date(s) of treatment	Problem for which treatment was sought	Did you find it helpful?	If yes, in what way was it helpful?	If not, in what way was it unsatisfactory?
		Y / N		
		Y / N		

4. Have you ever made a suicide attempt? No ___ Yes____ If Yes, please give date(s) _____

5. Have you ever purposely harmed yourself (cutting, burning, or other)? No ___ Yes___ If Yes, please indicate when this happened most recently _____

6. Have you ever been hospitalized in an inpatient or partial hospitalization program for mental or emotional difficulties or for drug or alcohol abuse? Yes _____ No_____ If Yes, please complete the following chart.

When were you hospitalized?	For how long?	Reasons for hospitalization or partial hospitalization	Was it voluntary?
			Y / N
			Y / N
			Y / N

7. Do you *currently* take medications or supplements to treat mental/emotional difficulties or substance. If yes, please complete the following chart. (Later in the questionnaire, you will be asked to list medications for other conditions.)

Medication Name	Dosage/ Frequency	When started?	Name of Prescriber	Prescribed for what symptoms?

8. Please list medications you have taken previously to treat mental or emotional difficulties or drug or alcohol abuse:

_____

_____

9. Do any biological relatives have any history of psychiatric, emotional and/or substance use problems?

	Family members
Hyperactivity/attention deficit disorder (ADHD)	
Alcohol or drug abuse	
Panic attacks or phobias or anxiety	
Depression	
Schizophrenia	
Bipolar disorder	
Neurological condition	
Other emotional problems	

Medical History

1. Have you ever had any serious, chronic or recurrent health problems or disabilities?

Yes ___ No___ If Yes, please describe:

	Past / Current
	Past / Current
	Past / Current

2. Have you ever had a head injury? Yes _____ No_____ If Yes, please describe:

_____

3. Are you currently taking medications for any physical health problems? Yes _____ No_____

If Yes, please complete the following chart.

Medication Name	When Started?	Prescribed for what symptoms?

4. What other health care recommendations are you following or aiming to follow?

_____

_____

5. List dates of any hospitalizations for physical problems:

Date Problem

_____

_____

6. When was your last physical examination by a physician? _____What was the outcome? _____

7. Do you exercise? Yes _____ No_____

If yes: how many times per week? _____ how many minutes on average? _____ mins.

8. Height:_____ Weight: _____

Other Background

1. Have you ever been involved in a lawsuit? Yes _____ No_____

If yes, please describe the circumstances and give dates:

_____

2. Have you ever been arrested? Yes _____ No_____

If yes, please describe the circumstances and give dates:

_____

3. Do you have a history of violent or aggressive behavior? Yes ___ No ____ If Yes, please explain:

_____

_____

4. Have you experienced any particular sources of stress in the last year? Yes _____ No_____

If Yes, please explain:

_____

_____

5. Are there any other health care professionals (e.g. physicians, psychotherapists) who have information that might help in your treatment? Yes ___ No___

6. Is there any other information that would be helpful to discuss in the consultation appointment?

_____

_____