Janet Dougherty, MS, LPC-S
907 West Main Street
Lewisville, TX 75067
214/538-4532

INTAKE QUESTIONNAIRE

The purpose of this questionnaire is to get a complete picture of your background. By asking you about these things in questionnaire form we can save a great deal of valuable therapy interview time. Therefore, answering these routine questions as full and as accurately as you can will make it possible for me to get to work on things that concern you much more quickly. (Use the back of this paperwork if more room is needed for any questions.)

CLIENT INFORMATION

Today's Date:_____

Name:_____

Address:_____

City:_____ Zip:_____

Phone (Home)_____ Phone (Cell) _____

Work:_____ Other:_____

Email:_____

Date of Birth:_____/_____/____ Age:_____

PARENTS AND SIBLINGS

Father's Name_____ Age:_____

Mother's Name: _____ Age:_____

Names and Ages of Brothers & Sisters
Please include any half and or step siblings:

1._____ Age_____

2._____ Age_____

3._____ Age_____

4._____ Age_____

MARRIAGE AND CHILDREN

*If you have never been married and or have no children then you can skip to the next section.

Current Marital Status:

Single _____ Engaged _____Married _____ Separated

_____Divorced _____Widowed

____ Remarried (indicate # of times) ____Significant Other

Spouse's Name (if married):_____

Spouse's Age:_____

Do you have children? Yes No

If yes, please list them below and designate step-children as ("Step").

1._____Age_____

2._____ Age_____

3._____Age_____

4._____Age_____

MEDICAL INFORMATION

Name and Phone of Family Physician:_____
_____

Please rate your health: Excellent Good Poor

Date of last physical:_____/_____/_____

Have you had any counseling before? Yes No

Counseling/Therapist Names:_____
Dates:_____ _____

Do you have an addiction? ___Yes ____ No ____Uncertain

Have you ever attempted suicide: _____ (if yes, when, method, result)_____

Have you ever been hospitalized for psychological problems?
If yes, why, where, when, length of time, and admitted by whom?_____
_____
_____

PERSONAL INFORMATION

In case of an emergency, who should be notified?

Name:_____

Address:_____

City:_____State____ Zip_____

Phone: Home: (____)_____ Cell: (_____)_____

Relationship:_____

Please answer the following questions

Please state in your own words the nature of your main problem(s) and what concerns have caused you to come for counseling at this time:

_____

_____

When did your problem(s) begin?_____

_____

What have you previously tried to do to resolve the problem? What was the outcome? _____

_____

Please describe any important events occurring at that time or since then which may have started your problem(s) or which keep them going:_____

_____

In order to understand me:_____

_____

_____

_____

My childhood was:_____

_____

_____

Please check those issues that concern you (check all that apply):

	Anxiety		Relational concerns		Alcohol concerns
	Depression		Sexual concerns		Drug concerns
	Anger		Sexual assault / abuse		Eating concerns
	Grief / loss		Childhood trauma		Family issues
	Other (Please specify)				

SYMPTOMS/BEHAVIORS (Check all that apply)

- ☐ Eating less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor concentration
- ☐ Crying
- ☐ Withdrawing socially
- ☐ Binge drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Depressed
- ☐ Shameful
- ☐ Afraid
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Out of control
- ☐ Numb
- ☐ Irritability
- ☐ Acting out sexually
- ☐ Acting aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Anxious
- ☐ Passivity
- ☐ Drug use
- ☐ Alcohol use
- ☐ Sexual problems
- ☐ Being good to yourself
- ☐ Socializing
- ☐ Marital relationships
- ☐ Parent/child conflicts
- ☐ Lack of ambition/goals
- ☐ Poor peer relationships