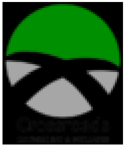

Crossroads Counseling and Wellness

Client Intake Questionnaire

Please fill in the information below in time for your first session.

Personal Information

Name____Date__________

Street Address____

City____________________________________State____________Zip Code___________

Cell Phone___________________________Email__________________________________

DOB:__________________________Age_____________Gender_____________

CHP#________________

Currently in **School** (circle one) Yes No If Yes, where___________________________

Education Grade____________ ◻ College ◻ Postgraduate

Employment ◻ Part Time ◻ Full Time Satisfaction (1-10) _______

Place of Employment____

Marital Status: ◻ Never Married ◻ Domestic Partnership ◻ Married

◻ Separated ◻ Divorced ◻ Widowed

Name of Previous Therapist/Psychiatrist? ◻ N/A ◻ Yes ______________________________

Previous Diagnosis____

Are you currently taking any prescription medication? ◻ Yes ◻ No If yes, please list:

____

____

____

1. How would you rate your **current physical health**? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

2. How would you rate your current **sleeping habits**? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: __________

3. How many times per week do you generally exercise? ___________________________

4. Please list any difficulties you experience with your **appetite or eating problems:**

5. Are you currently experiencing **overwhelming sadness, grief or depression?**

□ No □ Yes Approximately how long? _______________________________

6. Are you currently experiencing **anxiety, panics attacks or have any phobias?**

□ No □ Yes When was your first experience of anxiety attacks_____________

7. Are you currently experiencing any **chronic pain**?

□ No □ Yes If yes, please describe:

8. Do you **drink alcohol** more than once a week? □ No □ Yes

9. How often do you engage in **recreational drug use**?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a **romantic relationship**? □ No □ Yes

If yes, for how long? __________________________________

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? __________________________________

11. What **significant life changes or stressful events** have you experienced recently?

____

12. Do you consider yourself to be **spiritual or religious**? □ No □ Yes

13. What do you consider to be some of your **strengths**?

____

____

14. What do you consider to be some of your **weaknesses?**

____

____

15. What would you like to **accomplish** out of your time in therapy?

____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

		Family Member
Alcohol/Substance Abuse		______
Anxiety	yes/no	______
Depression	yes/no	______
Domestic Violence	yes/no	______
Eating Disorders	yes/no	______
Obesity	yes/no	______
Obsessive Compulsive Behavior	yes/no	______
Schizophrenia	yes/no	______
Suicide Attempts	yes/no	______

Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

____ ____________________
Client Signature (Client's Parent/Guardian if under 18) Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

____

Client Signature (Client’s Parent/Guardian if under 18)