Alison M. Acton, LMFT/EMDR Therapy

Client Intake Questionnaire

Date: _____

Name:_____Age:_____ DOB:_____
Address:_____City:_____State:_____Zip:_____
Cell phone:_____ Alternate phone:_____ E-mail:_____

Emergency Contact Information:
Name: _____ Relationship: _____ Phone number: _____

Are you currently employed? ____Yes ____No
If yes, what is your current employment situation?_____
_____

Previous Mental Health Treatment History:
Have you ever participated in any type of mental health services? Yes____ No____ *If yes, complete the following:*
Name of provider: _____
Type of Provider (Psychiatrist, Therapist, counselor, etc.): _____
Dates of treatment: from _____ to _____ Focus of treatment: _____
Have you ever been hospitalized because of a mental health disorder? Yes____ No____
Reason for hospitalization: _____
Hospitalization was: Voluntary ____ Involuntary ____ How long was your hospitalization? _____
Course of treatment during hospitalization. _____
_____

Medical Treatment Information:
How would you rate your current physical health?
____Poor ____Unsatisfactory ____Satisfactory ____Good ____Very Good
Do you currently have any medical conditions? Yes____ No____
Please list medical conditions and how long you have had them:_____
_____

Are you taking any prescription medication? ____Yes ____No
If yes please list medications:_____
_____
_____
_____

General and Mental Health Information:
Please list any difficulties you experience with your appetite or eating problems:_____
_____

Are you currently experiencing overwhelming sadness, grief, or depression? _____Yes _____No
If yes, for how long?_____

Are you currently experiencing anxiety, panic attacks, or do you have any phobias? _____Yes _____No
If yes, when did you begin experiencing this?_____

Are you currently experiencing any chronic pain? _____Yes _____No
If yes, please describe:_____

Alcohol and Other Drug Use History:
Do any of your family members struggle with substance abuse or addiction? Yes_____ No_____
If so, who? _____
Please check the substances you have used:

Opioid(s):	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Heroin:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Nicotine:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Alcohol:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Amphetamines:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Barbiturates:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Cocaine:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Crack:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Hallucinogens:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Inhalants:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Marijuana:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____
Other:	____	Age of 1st use: _____	Duration of use: _____	Frequency of use: _____

If you have indicated that you have used or are currently using substances, please indicate the side effects that you have experienced or are experiencing as a result of the use.

Overdose:	_____	Suicidal Impulse:	_____	Depression:	_____
Anxiety:	_____	Loss of control:	_____	Blackouts:	_____
Other:	_____	Medical conditions:	_____	Other:	_____

Have you ever participated in outpatient substance abuse treatment? Yes_____ No_____ *If yes, describe*:
_____
_____
Was the treatment method effective? *Please explain*: _____
_____

Relationship Status:
Are you currently in a romantic relationship? Yes_____ No_____ 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?
_____

Education Information (please check appropriate):

Elementary Grades 1-8: _____
Some High School: _____
High School Diploma/GED: _____
Some College: _____ Major: _____
College degree: _____ Major: _____
Technical/Trade School Graduate: _____ Trade Skill: _____

Military History:

Never served in the military: _____
Active duty: _____
Served in Military: _____
Have you ever been deployed? Yes_____ No _____
If yes, did any incidences or issues arise for you during or after your deployment?
_____
_____

Additional Information:

What significant life changes or stressful events have you experienced recently?_____
_____
_____
_____
_____

Do you consider yourself to be spiritual or religious? _____Yes _____No
If yes, describe your faith or belief:_____
_____
_____
_____

What would you like to accomplish out of your time in therapy?_____
_____
_____
_____
_____
_____

Payment Information:

Please indicate payment method: Cash: _____ Check: _____ Credit Card:_____