NuView Counseling LLC
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Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

**** Please note: Email correspondence is not considered to be a confidential medium of communication. ****

Personal Information.

Today's Date _____

Client's Name:_____

DOB: _____ Age: _____ Gender: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Another Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

Primary Insured_____ Relationship_____ DOB _____/_____/_____

Referred By (if any): _____

Client's Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Emergency Contact Information: (If Applicable)

Name_____Relationship_____

Address: _____ Phone: _____ Email:_____.

City:_____. State: _____. Zip:_____.

I give Charlie Brown, LPC, permission to contact the above listed emergency contact as he deems necessary for best practices and care for me.

X_____ Signature of client

Background Information:

1. Current personal home life summary:_____,

_____,

_____.

2. List Family Members (Living with or responsible for you currently)._____

_____

3. History of present Problem (Brief Summary):_____

_____.

General and Mental Health Information

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

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. Have you ever received any mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____.

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

_____

_____

4. Were you prescribed psychiatric medication in previous episodes? □ Yes □ No If yes, please list and provide dates:

_____

_____

5. Have you ever experienced major Trauma (As a Child, or an Adult)? □ Yes □ No If yes, please explain:

_____

_____

6. 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: _____

_____.

7. How many times per week do you generally exercise? _____ .

What types of exercise do you participate in? _____ .

8. Are you experiencing any difficulties with your appetite or have eating problems: _____

9. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

10. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

11. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

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

13. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

14. 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?_____

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

_____

_____

Please circle all the items that are currently a concern

1) Anger
2) Anxiety
3) Childhood Emotional Abuse
4) Childhood Physical Abuse
5) Childhood Sexual Abuse
6) Cutting
7) Depression
8) Divorce/Contemplation/Recovery
9) Excessive Alcohol/Drug Use
10) Family Relationships
11) Financial Concerns
12) Grief/Loss
13) Incest
14) Illness
15) Marital Relationships
16) Parenting Concerns
17) Physical Abuse/Violence
18) Physical Problems
19) Poor Communication
20) Premarital Counseling
21) Rape
22) Remarried Relationship
23) Self-esteem
24) Sexual Difficulties
25) Stress
26) Suicide Attempts
27) Suicidal Ideations
28) Verbal Abuse/Violence
29) Work related Issues
30) Other _____

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.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
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	_____

Education:

What is the highest level of Education completed? Grade_____ School _____.
Please check all attained: □ Diploma □ GED □ Bachelors □ Masters □ Doctorate

Additional Information:

1. Are you currently employed? □ No □ Yes □ Full-Time □ Part Time □ Contractor □ Self Employed

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____.

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

If yes, describe your faith or belief: _____
_____

3. What do you consider to be some of your strengths? _____
_____
_____
_____

4. What do you consider to be some of your weaknesses? _____
_____
_____
_____

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