RETURNING CLIENT INTAKE QUESTIONNAIRE

Please fill in the information below and bring it with you to your session.

INFORMATION PROVIDED ON THIS FORM IS PROTECTED AS CONFIDENTIAL INFORMATION

DATE:__________________________

DATE LAST SEEN BY DAWN:(approx.)__________________________

CLIENT NAME:____ **PREFERRED NAME:**________________________

CLIENT DATE OF BIRTH____________________________ **AGE:**_________________ **GENDER**______________________

PHONE ____ Is it OK to leave a message**?** YES NO Is it OK to text**?** YES NO

SECONDARY PHONE ____________________________ Is it OK to leave a message**?** YES NO Is it OK to text**?** YES NO

STREET ADDRESS_________________________________

CITY, STATE, ZIP _________________________________

******If you are a college student, please list your current address at school if not indicated to the left.***

STREET ADDRESS_________________________________

CITY, STATE, ZIP _________________________________

E-MAIL ____ Is it OK to send a message? YES NO

E-mail is not used to communicate protected health information, as e-mail is not considered to be a confidential form of communication

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1) Have there been any changes in your living situation since your last visit (relationship status, moved, children, etc.)? YES NO

If yes, please describe: ____

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2) Has there been changes in your employer, employment status or position/title/duties since your last visit? YES NO N/A

If yes, please describe: ____

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Employer____ Occupation/Position____

3) *FOR STUDENTS*: Has there been a change in your education status since your last visit (change school, graduate, etc.)? YES NO

If yes, please describe ____

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School attending________________________________ Grade/Level__________________________________ Status: FT PT

4) Have you had any major illnesses, chronic pain, injuries, medical treatments, or surgeries since you last visit? YES NO

If so, please explain____

5) Have you been hospitalized or received inpatient treatment for mental health or substance abuse since your last visit? YES NO

If yes, Reason____ Dates (approx.) _________________ Location____________________

6) Has there been an increase in your alcohol/recreational drug use since last session? YES NO

If yes, Type__________________________________ Frequency________________________ Amount________________________

7) Are you currently taking any prescription medication for mood/anxiety/focus management? YES NO

If yes, please list

Medication_______________________________ Dosage__________________ Managing Practitioner ________________________

Medication_______________________________ Dosage__________________ Managing Practitioner ________________________

Medication_______________________________ Dosage__________________ Managing Practitioner ________________________

8) Do you have/had any legal issues since your last visit (e.g. DUI, criminal, child custody, divorce, lawsuit, bankruptcy)? YES NO

If yes, please explain ____

9) Have you experienced any significant losses, life changes or stressors in the past year? YES NO

If yes, please explain ____

10) What issues would you like to address in counseling? ____

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