

**Rebecca Zulim, M.A., LMFT**  
**Patient Intake Questionnaire**

**General:**

Name \_\_\_\_\_  
Date \_\_\_\_\_ Address \_\_\_\_\_  
Home phone \_\_\_\_\_  
Work phone \_\_\_\_\_ Fax \_\_\_\_\_  
E-mail \_\_\_\_\_ Referred by \_\_\_\_\_  
Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
Marital status \_\_\_\_\_ Occupation \_\_\_\_\_  
Names and ages of children \_\_\_\_\_  
\_\_\_\_\_  
Emergency contact information \_\_\_\_\_  
Explanation of how patient may be contacted by therapist \_\_\_\_\_  
\_\_\_\_\_

Patient Questionnaire/Intake 2

**Financial Information:**

*If planning to use health insurance:*

Name of insurance company \_\_\_\_\_  
Policy number \_\_\_\_\_ Group number \_\_\_\_\_  
Telephone number \_\_\_\_\_

**Areas of Concern**

What issues/concerns causes you to seek treatment? Please describe. \_\_\_\_\_  
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Do you have any specific goals with regard to your treatment? \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any particular concerns/fears with regard to treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Psychological History:**

Have you ever received mental health treatment before? \_\_\_\_\_

When and for how long? \_\_\_\_\_

What was the focus of treatment? \_\_\_\_\_

Name of treating therapist(s), address(es), telephone number(s) \_\_\_\_\_

\_\_\_\_\_

An authorization for release of confidential information would be required to contact any former therapist.

Have you ever been subjected to one or more psychological tests? \_\_\_\_\_

If so, by whom? \_\_\_\_\_

Name of person(s) administered psychological tests, address(es), telephone number(s) \_\_\_\_\_

**Patient Questionnaire/Intake 3**

An authorization for release of confidential information would be required to contact any former test administrator.

Have you ever been hospitalized for mental or emotional problems? \_\_\_\_\_

When and for how long? \_\_\_\_\_

Why were you hospitalized? \_\_\_\_\_

Name of treating therapist, address, telephone number \_\_\_\_\_

An authorization for release of confidential information would be required to contact any former therapist.

Are you currently taking any prescription medications? \_\_\_\_\_

What prescriptions and dosage? \_\_\_\_\_

Prescribed by whom? \_\_\_\_\_

How long have you been on the medications? \_\_\_\_\_

Have you ever taken any medications for a mental or emotional condition? \_\_\_\_\_

What was taken, when and for how long? \_\_\_\_\_

\_\_\_\_\_

An authorization for release of confidential information would be required to contact any health care provider.

Have you ever attempted suicide? \_\_\_\_\_

When? \_\_\_\_\_

Describe the circumstances that led to that attempt. \_\_\_\_\_

\_\_\_\_\_

Are you currently having any suicidal thoughts? Please describe \_\_\_\_\_

\_\_\_\_\_

Please describe your childhood. \_\_\_\_\_

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

\_\_\_\_\_

Have you ever been a victim of a violent crime? Please describe \_\_\_\_\_

**Medical History**

Have you ever been diagnosed with a serious illness? Please describe \_\_\_\_\_

Do you have any medical conditions that may affect your mental health treatment? \_\_\_\_\_  
Please describe your overall health today. \_\_\_\_\_

Patient Questionnaire/Intake 4

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. \_\_\_\_\_

Have you ever been in a 12-step program? Please describe. \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_

On average, how much alcohol do you consume in a week? \_\_\_\_\_

Do you currently use illegal drugs? Please describe your use \_\_\_\_\_

Have you ever used illegal drugs? Please describe. \_\_\_\_\_

**Family of Origin History**

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. \_\_\_\_\_

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. \_\_\_\_\_

Names and ages of siblings. \_\_\_\_\_

**Other Information**

Please describe your spiritual identity/orientation. \_\_\_\_\_

Please describe your interests/hobbies \_\_\_\_\_

Are you now or have you ever been involved in a lawsuit? \_\_\_\_\_

Please describe. \_\_\_\_\_

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. \_\_\_\_\_