Patrick Hyland
Licensed Professional Counselor – Registered Intern
State of Oregon

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INTAKE QUESTIONNAIRE

(*Please print Clearly)*

CLIENT INFORMATION

Date: _____ Social Security Number: _____N/A_____ Gender: ____

Name: _____ DOB: _____

Address: _____ Age: _____

_____

_____

Telephone: _____ Alternate: _____

Name of Spouse/Guardian: _____ Age: _____

Address: _____

_____

_____

Telephone: _____ Alternate: _____

Additional Information: _____

_____

Insurance Company for services: _____

Person Responsible for Payment: _____

Address: _____

_____

Telephone: _____

Agreed Session Cost: $_____ Client Signature: _____

Marital Status (more than one answer may apply)

Single ____ Divorce in Process ____ Unmarried, living together ____

Since _____

Legally Married ____ Separated ____ Divorced ____

Since _____ Since _____ Since _____

Assessment of current relationship: Good ____ Fair ____ Poor ____

EMERGENCY INFORMATION (In case of emergency, contact):

Name: _____ Relationship: _____

Address: _____

_____

Telephone: _____ Alternate: _____

Primary Physician: _____

Telephone: _____ Alternate: _____

Psychiatrist: _____

Telephone: _____ Alternate: _____

Other: _____

Telephone: _____ Alternate: _____

Medications: _____

Allergies: _____

Important Medical Conditions: _____

Are you allergic to any medications or drugs? _____

Signature for Services to Begin: _____

Client:

Date: _____

Agreed by Therapist: _____ Date: _____

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Referral Source:

How did you hear about me? _____
Who referred you? _____
Telephone of referral person: _____
Relationship of referral person to client: _____

Employment:

Client's Work: _____

Supervisor's Name: _____

Telephone: _____ Alternate: _____

Spouse's Work: _____

Supervisor's Name: _____

Telephone: _____ Alternate: _____

Family:

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	_____	____	___	___	___	___
Father	_____	____	___	___	___	___
Spouse	_____	____	___	___	___	___
Children	_____	____	___	___	___	___
	_____	____	___	___	___	___
	_____	____	___	___	___	___
	_____	____	___	___	___	___
	_____	____	___	___	___	___

Others: _____

_____

Parental Information:

Parents married/divorced: _____ Since: _____

Father Remarried yes/no Remarried number of times: ____
Mother Remarried yes/no Remarried number of times: ____

Military:

Military Experience? Yes ____ No ____ Combat? Yes ____ No ____
If Combat, describe location, length, unit, etc.: _____
_____

Branch: _____ Discharge type: _____
Date enlisted: _____ Discharge date: _____
Rank at discharge: _____ Military disabilities: _____
_____
Other important information: _____

PRIMARY REASONS FOR SEEKING SERVICES (Mark all that apply):

Anger Management ____ Anxiety ____ Coping ____ Depression ____
Eating Disorder ____ Fear/Phobia ____ Mental Confusion ____
Sexual Concerns ____ Sleeping problems ____ Addictions ____
Alcohol/drugs ____ Other _____

Do you feel suicidal or intend to harm yourself at this time? Yes ____ No ____

What are your goals for therapy? _____
_____

Prior Counseling:

Have you received prior counseling? Yes ____ No ____
Type of counseling: _____
Name of Provider: _____

Please check if there have been any recent changes in any or all of the following:

Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level ____
Physical activity level ____ General disposition ____ Nervousness/tension ____

Describe any recent changes: _____
_____

Development Information:

Any special, unusual, or traumatic circumstances that affected your development/growing up?
_____
_____
Any history of child abuse (sexual, physical, verbal) _____
(Describe, if applicable): _____
_____
_____

Social Relationships:

Check how you generally get along with people (check all that apply):

Affectionate ____	Aggressive ____	Avoidant ____	Fight/Argue ____
Friendly ____	Follower ____	Leader ____	Shy ____
Submissive ____	Outgoing ____	Other _____	

Spiritual/Religious:

How important are spiritual/religious matters? Not ___ Little ___ Moderate ___ Much ___
Are you affiliated with a spiritual/religious group? _____
If so, describe _____
Were you raised within a spiritual/religious group? Yes ___ No ___
If yes, describe _____
Would you like your spiritual/religious beliefs incorporated into counseling? Yes ___ No ___

Legal:

Are you involved in any active legal cases (traffic, civil, criminal)? Yes ____ No ____

If yes, describe: _____

If yes, describe the location/jurisdiction: _____

Charges/hearing/trial dates: _____

Are you presently on probation or parole? Yes ____ No ____
If yes, describe: _____

Traffic violations?	Yes ____ No ____	Total number of violations: _____
DWI, DUI, Etc.	Yes ____ No ____	Total number of violations: _____

Notes/Comments: