EFT

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Licensed Marriage and Family Therapist #77166

Intake Questionnaire

Client name: _____ **Date:** _____

1. What brings you to therapy at this time? Is there something specific, such as a particular event? Please be as detailed as you can.

2. What are your goals for therapy?

3. Have you seen a mental health professional before? If yes, when was the last time? And about how many sessions did you attend?

4. Specify all medications and supplements you are currently taking, including dosages and reason for the medication.

5. If taking prescription medications, who is your prescribing Doctor? Please include type of Doctor, name, and phone number.

6. Who is your primary care physician? Please include type of Doctor, name, and phone number.

7. Do you drink alcohol?

8. Do you use any recreational drugs? Or smoke cigarettes?

9. Do you, or have you ever had any suicidal thoughts? If yes, when was the last time?

10. Do you ever have thoughts or urges to harm others? If yes, when was the last time?

11. Have you ever been hospitalized for a psychiatric issue? If yes, when and what was the issue?

12. Is there a history of mental illness or emotional issues in your family? If yes please state relationship to you and the type of issue.

13. If you are in a relationship please describe the nature of the relationship and months or years together?

14. Describe your current living situation. Do you live alone, with others, with family, ect…?

15. What is your level of education? Highest grade/degree and type of degree?

16. What is your current occupation? What do you do? How long have you been doing it?

17. Please circle any of the following you have experienced in the past 6 months

a. Increased appetite
b. Decreased appetite
c. Trouble concentrating
d. Difficulty sleeping
e. Excessive sleep
f. Nightmares
g. Low motivation

h. Isolation from others
i. Fatigue/low energy
j. Low self-esteem
k. Depressed Mood
l. Tearful or crying spells
m. Anxiety
n. Fear
o. Hopelessness
p. Panic
q. Other_____

18. Please circle any of the following that apply and include the date of occurrence, or diagnosis.

a.	Headaches	Date_____
b.	High Blood Pressure	Date_____
c.	Gastritis or esophagitis	Date_____
d.	Hormone related problems	Date_____
e.	Head Injury	Date_____
f.	Angina or Chest Pain	Date_____
g.	Irritable Bowel	Date_____
h.	Chronic Pain	Date_____
i.	Loss of Consciousness	Date_____
j.	Heart Attack	Date_____
k.	Bone or Joint Problems	Date_____
l.	Seizures	Date_____
m.	Kidney related issues	Date_____
n.	Chronic Fatigue	Date_____
o.	Dizziness	Date_____
p.	Faintness	Date_____
q.	Heart Valve Problems	Date_____
r.	Urinary Tract Problems	Date_____
s.	Fibromyalgia	Date_____
t.	Numbness and Tingling	Date_____
u.	Shortness of breath	Date_____
v.	Diabetes	Date_____
w.	Hepatitis	Date_____
x.	Asthma	Date_____
y.	Arthritis	Date_____
z.	Thyroid issues	Date_____
aa.	Cancer	Date_____
bb.	Other _____	Date_____

19. What else would you like me to Know?