DEBORAH G. MATHER, PH.D.
THERAPY FOR INDIVIDUALS · GRIEF & LOSS
PY0727 · PSY17113

# CLIENT INTAKE QUESTIONNAIRE

Please fill in the information below and email to **deborahmather@att.net** prior to your first therapy session.
**Please note:** Information provided on this form is protected as confidential information.

## PERSONAL INFORMATION

Name: ________________________ Date: ________________________

Parent/Legal Guardian (if under 18): ________________________

Address: ________________________

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

Cell/Work/Other Phone: ________________________ May we leave a message? □ Yes □ No

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

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

DOB: ____________ Age: ________ Social Security Number: ______-______-______

Gender: □ Male □ Female

Employer or School: ________________________ Employment Status: ____________

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred by ***or*** Primary Dr. Name: ________________________

**Is the patient covered by Insurance?** □ **YES** (Complete Section II and Section III) □ **NO** (Complete Section V)

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## INSURANCE INFORMATION - SECTION II

Patient relationship to insured: □ Self □ Spouse □ Child □ Other

- If patient **is** the insured go directly to Section III.
- If **"patient relationship to insured"** *is other than* **"Self"** please complete the following:

Insured's Name: ________________________

Address: ________________ City: ____________ State: ________ Zip: ________

Telephone: ________________ Work: ____________ Cell: ____________

DOB: ____________ Age: ________ Social Security Number: ______-______-______

Marital Status: ________________________ Gender: □ Male □ Female

Employer or School: ________________________ Employment Status: ____________

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## INSURANCE POLICY INFORMATION - SECTION III

□ Medicare □ Medical □ Other

Insurance Company: ______________________________

Address: ______________ City: ______________ State: ________ Zip: ________

Plan Name: ______________ Policy#: ______________ Group#: ______________

**Is the patient covered by more than one Insurance?** □ **YES** (Complete Section IV) □ **NO**

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## SECONDARY INSURANCE POLICY INFORMATION - SECTION IV

□ Medicare □ Medical □ Other

Insurance Company: ______________________________

Address: ______________ City: ______________ State: ________ Zip: ________

Plan Name: ______________ Policy#: ______________ Group#: ______________

**Is the patient covered by more than one Insurance?** □ **YES** (Complete Section IV) □ **NO**

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## BILLING INFORMATION - SECTION V

- Complete **ONLY** if there is no insurance for the patient

**Who is responsible for charges for this patient?** □ **Patient** □ **Other** (Please complete the following information)

Name: ______________________________

Address: ______________ City: ______________ State: ________ Zip: ________

Telephone: ______________ Work: ______________ Cell: ______________

DOB: ______________ Age: ________ Social Security Number: ______-______-______

Marital Status: ______________________________ Gender: □ Male □ Female

Employer or School: ______________________ Employment Status: ______________

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## HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: ______________________________

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list: ______________________________

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates: ______________________________

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## GENERAL AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

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

______________________________

2. How would you rate your current sleeping habits? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

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

______________________________

3. How many times per week do you generally exercise? ______________________________

What types of exercise do you participate in? ______________________________

4. Please list any difficulties you experience with your appetite or eating problems: ______________________________

______________________________

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

If yes, for approximately how long? ______________________________

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

If yes, when did you begin experiencing this? ______________________________

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

If yes, please describe: ______________________________

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

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? ______________________________

On a scale of 1-10 (1 being poor and 10 being exceptional), how would you relate your relationship? ____________

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

______________________________

______________________________

______________________________

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## 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.)

| | | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | □ No □ Yes | |
| Anxiety | □ No □ Yes | |
| Depression | □ No □ Yes | |
| Domestic Violence | □ No □ Yes | |
| Eating Disorders | □ No □ Yes | |
| Obesity | □ No □ Yes | |
| Obsessive Compulsive Behavior | □ No □ Yes | |
| Schizophrenia | □ No □ Yes | |
| Suicide Attempts | □ No □ Yes | |

## ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?______________________________

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? ______________________________

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