McAtee Psychology

Client Intake Questionnaire

All information provided is confidential and used solely for treatment purposes for the clients listed below. Please complete the following form with the **primary client** in mind.

Contact Information

Primary Client(s)

Today's Date:_____

Name/DOB:_____

Name/DOB:_____

Name/DOB:_____

Referred Source (if any): _____

Parent/Legal Guardian (if under 18):

Name/DOB:_____ Name/DOB:_____

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 □ N

Primary Concerns

1. What would you like to accomplish out of your time in therapy?

2. List three primary areas of concerns:

3. Describe how long these concerns have been going on? How frequent and intense are the concerns?

4. List areas of strengths:

5. List areas of weakness/concern:

6. List any strategies that you have attempted so far to address the main areas of concerns?

Client History

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

3. Have you received any suspected or formal diagnoses? □ Yes □ No
If yes, please list:

4. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

Family History: Has anyone in your family ever been treated for any of the following? Please check all that apply and when appropriate indicate paternal (P) or maternal(M).

	Father	Mother	Brother(s)	Sister(s)	Children	Grandma	Grandpa	Other Family
Depression								
Anxiety								
Panic Attacks								
PTSD								
Bipolar								
Schizophrenia								
Alcohol problems								
Drug problems								
ADHD								
Other								

Please describe details for each medication in the boxes below, including any other medications not listed above (birth control pills, over the counter medication, herbal remedies such as decongestants, St. John's Wort, etc.).

Name of Medication	Dosage and times/day (i.e., 50mg 3x/day)	Taking for how long (years and months)	Side Effects (if any)

List all prior serious illnesses, surgeries, and hospitalizations for medical illnesses.

_____
_____
_____

List any other relevant information:

_____
_____
_____

Please bring in any other supporting documents and assessments that will be helpful in the therapeutic process.