JMK Counseling Services, PC
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Intake Questionnaire

General Information:

Date: _____

Client Name: _____ Maiden Name: _____

Address: _____

City _____ State_____ Zip_____

Home Phone: _____ Ok to leave messages? Yes No

Cell Phone: _____ Ok to leave messages? Yes No

Date of Birth: _____ Age: _____ Relationship Status: _____

Employment/Occupation: _____

Sex: _____ Ethnicity: _____ Marital Status: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Physician: _____ Approximate date of last visit: _____

Would you be willing to sign a release so I can speak with your physician?

- Yes
- No

Current medications/dosages: _____

_____

Reason for medications: _____

_____

Significant medical conditions: _____

_____

Do you need a monthly billing statement for your insurance company?

- Yes*
- No

*Please note that it is your responsibility to call your insurance company to determine the requirements for reimbursement. Most insurance plans require a mental health diagnosis to be provided by your therapist. If you are concerned about a mental health diagnosis being provided to your insurance company, please discuss this with me.

How did you hear about Jessica? (please check one)

- Referral: _____
- Google/website – jessicakuhn.com
- Facebook
- Psychology Today online profile
- Other: _____

Is it okay for Jessica to contact your referral source to thank them for referring a client?

- Yes
- No

Areas of Concern:
What brings you to therapy? Why now? Please describe.

Please circle any of the following you may be experiencing:

Grief and Loss	Problems with anger/temper	Parenting Concerns
Anxiety/Fears/Stress	Depression	Financial problems
Compulsions	Stomach problems	Eating disorder
Sexual problems	Drug abuse/problems	Career concerns
Health problems	Low self-esteem	Relationship problems
Sexual temptations or habits	Separation/Divorce	Decision-making problems
Suicidal thoughts	Sleep problems	Legal matters
Alcohol abuse/problems	Drug abuse/problems	Unsure
Abuse – physical, verbal, sexual	Other:	

What are your goals for therapy?:

Do you have any concerns or fears regarding therapy?:

Family Information and Support Network:

Parent's Name: _____ Age: _____

If deceased, when and what was the cause of death?

Describe your relationship with this parent.

Parent's Name: _____ Age: _____

If deceased, when and what was the cause of death?

Describe your relationship with this parent.

Names and Ages of Siblings:

If deceased, when and what was the cause of death?

What is/was your relationship like with your siblings?

Please list names and ages of any children you have. If deceased, when and what was the cause of death?

Please list the members of the people you currently live with and describe the relationship you have with them.

Please list members of your support network, and describe the support/relationships.

Other Social History Information:
Please list divorces, separations, job loss, traumatic experiences, legal issues, victimization, etc.

Mental Health History:

Have you previously received any psychiatric, psychological, and/or counseling help? Yes No

If yes, please list past providers:

If yes, please list past diagnoses, medications, and outcomes of past treatments:

Would you be willing to sign a release so I can speak with your previous therapist? Yes No

Have you ever felt suicidal? Yes No
If yes, please describe:

Are you currently feeling suicidal? Yes No

If yes, do you have a plan for how to kill yourself or when you might do it? Yes No

Have you ever been hospitalized for mental health treatment? Yes No
If yes, when and for how long?

Do you drink alcohol? Yes No
On average, how many drinks do you consume within a week? _____

Do you use marijuana? Yes No
On average, how much marijuana do you consume within a week? _____

Do you take illicit drugs? Yes No
Please list which drug(s) and how much you consume.

Have you ever been in a 12-step program? If yes, when and for how long?

Academic/Work/Occupation:

Grade level (children/adolescents):

Performance/grades (children/adolescents):

Learning/behavioral issues (children/adolescents):

Suspensions/excessive absences (children/adolescents):

Peer relationships (children/adolescents/adults):

Occupation (adults):

Work history (adults):

Personal Assets and Liabilities:

What are your coping tools?

What are your hobbies/interests/achievements? Things you are proud of?

What are the barriers to meeting your goals?

Please add any additional information you think may be helpful in our work together: