Barbara Dunn, PhD, LICSW, MT-BC • Psychotherapy Practice
Intake Questionnaire

Please complete and bring this confidential form to your appointment. Feel free to leave any questions blank that you don't understand or don't want to answer at this time.

Your name ________________________________ DOB ___________ Date _________________

Home address ____________________________________ City _____________ Zip __________

Home phone ___________________ Cell phone ___________________ Message OK? _________

Work phone ____________________ Email ____

Insurance Co _________________________ Policy # ____________________________________

Relationship status: Single ____ Married/Partnered ____ Separated/Divorced ____ Widowed _____

Significant other (name) ___________________________________ Phone __________________

Children: Name ____________________________ Age _______ Lives at home? _________

Name ____________________________ Age _______ Lives at home? _________

Name ____________________________ Age _______ Lives at home? _________

Emergency Contact: Name _________________________________Phone _____________________

Occupation ____

Current employer ____

Education, most recent degree or grade completed ____

Referred by ____

Medical Information

Please list name/phone number of current health care provider(s) *Including alternative practitioners*

____

____

Current Medical and/or Psychiatric Conditions/Diagnosis

____

____

Purpose for seeking therapy at this time ____

____

Previous interventions you have tried ____

____

How would you rate your general physical health? Excellent ___ Good ___ Fair ___ Poor ___

Family History Please circle items that apply and note whom it concerns.

C-You/Client, UK–Unknown, M-Maternal, P-Paternal, S-Sibling

Depression _____________
Anxiety ________________
Bipolar Disorder ________
Heart Disease _________
ADD/ADHD ___________
Sleep Disorder _________
Asthma ________________

Autism/Asperger's/PDD ________________________
Criminal History _________
Victim of a crime _________
O.C.D. __________________
Substance Abuse _________
Divorce _________________

Sexual Abuse _____________
Physical Abuse __________
Emotional Abuse ________
Exposure to Domestic Violence _______________
Head Injury ______________
Other____________________

Trauma History

____ Yes ____ No I have been exposed to a traumatic event(s) in which I experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others AND my response involved fear, helplessness or horror.

Substance Abuse History

Please note any problems with substance use or abuse

____

Have you received treatment for drug or alcohol abuse? ____ If yes, where? ____________________

What do you do to maintain sobriety? ____

____

Self Care

Do you do any of the following? If yes, please describe:

Exercise ____
____

Meditation ____

Other self-care activities ____

What do you do for enjoyment? ____
____

What do you do to de-stress or relax? ____

Do you have religious or spiritual beliefs that are important to you? If yes, please explain.
____

Do you have a support network? If yes, please list your supports.
____

Please provide any additional information that is important for me to know.
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MEDICATION/SUPPLEMENT LIST

Date Started (Est OK)	Name of Medication Or Supplement	Dosage/ Frequency	Name of Prescriber	Reason For Taking the Medication	Date D/C

Thank you for taking the time to complete this form.