Leslie C. Simmons, LCSW
Professional Counseling & Psychotherapy

INTAKE QUESTIONNAIRE

PERSONAL INFORMATION

NAME_____

PHONE _____ ok to text? _____ y _____ n

ADDRESS_____

CITY _____ ZIP _____

EMAIL_____ ok to email? _____ y _____ n

PREFERRED PRONOUNS: (CIRCLE ONE)

SHE / HER HE / HIM THEY / THEM ZE / HIR

WHAT IS YOUR CURRENT GENDER IDENTITY?

____MALE ____FEMALE _____ TRANS (MTF) _____TRANS (FTM)

COMMENTS: _____

WHAT IS YOUR SEXUAL ORIENTATION, IF APPLICABLE? _____

COMMENTS: _____

BIRTHDATE _____ AGE _____

EMPLOYMENT/STUDENT: WHERE_____FULL-TIME _____ PART-TIME_____

HOW LONG? _____ STRESS LEVEL (SCALE OF 1- low to 10- high) _____

REFERRED BY_____

IN CASE OF EMERGENCY NOTIFY _____

RELATIONSHIP_____ PHONE _____

PAYMENT INFORMATION

**All payment is due at time of service.
Forms of payment accepted are cash, check and credit/debit/HSA card (add 4 % service fee).
A credit card is requested to guarantee any missed sessions with less than a 24 hour notice.
Your full session charge (plus 4%) will be applied to your card in this event.

Type of card _____

Card number _____

exp. date _____ 3 digit security code _____ billing zip code _____

I understand the above-referenced policy and agree. Please initial _____

COUNSELING INFORMATION

PLEASE DESCRIBE THE EVENT(S) THAT OCCURRED WHICH INFLUENCED YOUR DECISION TO COME TO COUNSELING:

WHAT HAVE YOU ALREADY TRIED TO DO ABOUT YOUR CONCERN?

HAVE YOU EVER BEEN TO COUNSELING OR PSYCHOTHERAPY? _____ YES _____ NO
COMMENTS

PLEASE MARK AN "X" ON THE LINE BELOW AT A POINT THAT REFLECTS YOUR FEELINGS ABOUT RESOLVING THE CONCERN.

very hopeful	somewhat hopeful	unsure	somewhat hopeless	very hopeless

MEDICAL INFORMATION

DESCRIBE ANY EXISTING MEDICAL PROBLEMS OR CURRENT PHYSICAL SYMPTOMS:

PLEASE LIST ANY MAJOR PAST ILLNESSES/SURGERIES/HOSPITALIZATIONS:

LIST ALL PRESCRIBED OR NON-PRESCRIBED MEDICATIONS YOU TAKE ON A REGULAR BASIS:

FAMILY INFORMATION

MARITAL STATUS:

_____ single _____ married/partner _____ divorced_____ widowed

FOR WOMEN:

HOW MANY PREGNANCIES? _____ LIVE BIRTHS: _____ MISCARRIAGES: _____

PLEASE DESCRIBE ANY FAMILY HISTORY OF PSYCHOLOGICAL PROBLEMS:

PLEASE DESCRIBE YOUR FAMILY'S USE OF ALCOHOL/DRUGS:

PLEASE LIST THE FIRST NAMES, AGES AND RELATIONSHIPS OF THE PEOPLE YOU LIVE WITH:

NAME	RELATIONSHIP	AGE

PLEASE DESCRIBE (EXCELLENT, GOOD, POOR OR FREQUENCY OF USE):

HEALTH_____ SLEEP_____

APPETITE_____ ENERGY LEVEL_____

TOBACCO USE_____ ALCOHOL USE_____

DRUG USE_____ CAFFEINE USE_____

HAVE YOU TRIED:

_____ MARIJUANA _____ INHALANTS _____ COCAINE _____ ECSTASY

_____ LSD _____ ROHYPNOL _____ METHAMPHETAMINES _____OTHER (Please describe)

PLEASE CHECK ANY SPECIFIC ISSUES YOU HAVE CONCERNS ABOUT:

RELATIONSHIP W/ PARTNER _____ FAMILY MEMBERS _____

COWORKERS_____ DEATH OR LOSS OF SIGNIFICANT PERSON _____

RESTLESS, RACING THOUGHTS _____ DATING/ROMANTIC RELATIONSHIPS _____

SPIRITUAL CONCERNS _____ SEXUAL CONCERNS _____

ETHNIC/RACIAL CONCERNS _____ SELF ESTEEM/SELF CONFIDENCE _____

ASSERTIVENESS/SHYNESS _____ DECISION-MAKING ABILITIES _____

EDUCATION/CAREER _____ ABUSE/PHYSICAL/SEXUAL/EMOTIONAL _____

ANXIETY/PANIC _____ ALCOHOL ABUSE _____

PHYSICAL STRESS (HEAD ACHES, STOMACH ACHES, ILLNESS) _____

PERFECTIONISM _____ DIFFICULTY CONCENTRATING _____

DEPRESSION _____ LONELINESS _____

FOOD ISSUES _____ BODY ISSUES _____

MOTIVATION/PROCRASTINATION _____ FINANCIAL CONCERNS _____

PLEASE COMMENT ON ANY EXPERIENCE WITH PHYSICAL/SEXUAL/EMOTIONAL ABUSE:

WHO IS YOUR PRIMARY SUPPORT SYSTEM (FRIENDS, CHURCH, FAMILY, SIGNIFICANT OTHER, ETC)?

HAVE YOU THOUGHT OF PHYSICALLY HARMING YOURSELF OR SOMEONE ELSE RECENTLY?

_____ YES _____ NO

HAVE YOU EVER ATTEMPTED TO PHYSICALLY HARM YOURSELF OR SOMEONE ELSE?

_____ YES _____ NO

DO YOU AGREE NOT TO PHYSICALLY HARM YOURSELF OR OTHERS?

_____ YES _____ NO _____ NOT SURE

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL?

Thank you!!
Leslie C. Simmons, LCSW