Sheri Leider, MSW, LCSW
Client Intake Questionnaire

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for counseling.

Name_____ Date of birth_____

Parent/legal guardian if under age 18_____

What gender do you identify with? _____

Address_____

City,State,Zip_____

Cell/Work/Other phone _____May we leave a message or text_____

Email _____ May we leave a message____

*please note:Email is not considered to be a confidential medium of communication

Occupation_____

Employer_____

Highest level of education_____

How satisfied are you with your job? _____

Briefly describe your reason(s) for seeking help at this time_____

_____

_____

What do you wish to accomplish through the therapy process_____

_____

_____

Have you ever been in therapy/counseling before _____

If yes, briefly describe the reason(s), dates and length of treatment_____

_____

Was it a positive experience? _____

Have you ever received a mental health diagnosis and if so, what was the diagnosis(es) _____

Have you ever attempted suicide? If yes please describe with dates_____

Have you ever seriously contemplated suicide? ____Yes____NO

Are you currently having suicidal thoughts? ___Yes_____No

Are you presently taking any medications? If yes, please list_____

Have you ever been prescribed psychiatric medication(s)_____

_____

Do you have any legal issues _____

Present _____Past_____

What do you enjoy doing in your spare time?

_____

Are there things that you used to do, or would like to do,but currently don't?_____

_____

How would you describe your spiritual or religious beliefs?

_____

Is there anything else you think would be important for me to know about you or your family?

_____

_____

_____

4.

Marital/Relationship Status (check all that apply):

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Remarried

☐ Single ☐ Long term relationship ☐ Co-habitating ☐ Other: _____

Current partner's name: _____

Partner's occupation: _____

Partner's Date of Birth: _____

Length of relationship: _____

How satisfied are you with this relationship? _____

Do you have any children (biological, adopted, foster, step, etc.)? ☐ Yes ☐ No

If yes, please list names and ages: _____

_____

_____

Do your children currently live with you? ☐ Yes ☐ No

If no, where do they live? _____

How often do you see them? _____

If you have been previously married, please complete the following:

1st marriage: Date married: _____ Date ended: _____

Children: ☐ Yes ☐ No Ex-spouse's name: _____

Reason for divorce: _____

2nd marriage: Date married: _____ Date ended: _____

Children: ☐ Yes ☐ No Ex-spouse's name: _____

Reason for divorce: _____

5.

Did someone refer you? ☐ Yes ☐ No If yes, who? _____

May I contact him or her to thank them for referring you? ☐ Yes ☐ No

If you were not referred by someone, how did you find my practice? _____

Please circle any of the following that presently cause you difficulty:

Assertiveness	Health Problems	Career choices	Stomach problems
Parenting	Alcohol use	Legal matters	Self-concept
Bowels	Sexual problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation
Energy	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Sleep difficulties	Infertility	Decision making
Physical abuse	Children	Parents	Sexual orientation
Education	Divorce	Relaxation	Infidelity
Temper	Depression	Sexual abuse	Shyness
Stress	Inferiority	Friends	Dating
Memory	Drug use	Headaches	Tiredness
Finances	Appetite	Anxiety	Unhappiness
Fears	Worry	Work	Confusion
Premarital	Food	Relationships	Self-control
Sadness	Grief/loss	In-laws	My past
Guilt	Eating disorder	Lack of self-confidence	Other:

_____

_____

6.

Life History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive picture of your background. If you do not desire to answer any questions, merely write "Do not care to answer". Feel free to write on the back of the page.

Personal Data

Date of Birth_____ Place of Birth_____

Mother's condition during pregnancy (as far as you know)_____

Circle any of the following that apply during your childhood:

Night Terrors	Bedwetting	Sleepwalking	Thumb sucking
Nail Biting	Stammering	Fears	Happy childhood
Unhappy childhood			

Health during childhood?_____ List Illnesses: _____

_____

Health during adolescence?_____ List Illnesses: _____

_____

What is your height?_____ Weight_____ Any accidents: _____

What are your five main fears?

1._____

2._____

3._____

4._____

5._____

Present interests, hobbies, and activities:_____

_____

How is most of your free time occupied?: _____

_____

What is the last grade of school you completed? _____

Scholastic abilities, strengths and weaknesses:_____

_____

Were you ever bullied or severely teased?_____

Did you make friends easily?_____ Do you keep them?_____

If you use alcohol or drugs please answer the following:

Do you use the following and if so, please state how often (be specific-daily, weekly, monthly, more/less)

Marijuana_____ Nicotine_____ Cocaine_____

LSD_____ Alcohol_____ Prescription Drugs_____

Other_____

7.

How much do you use?_____

Have you ever been arrested for driving while intoxicated?_____

If Yes, When (Date/s)?_____

Has your drug/alcohol use been pointed out by anyone in or outside of the family as a problem? If so, please explain: _____

_____

_____

_____

Does your personality change when you use?_____ How: _____

_____

Has your behavior become more hostile and caused conflict with anyone else when you've been under the influence of drugs/alcohol?_____ With Whom?___

_____

Have you ever had periods of time that you cannot remember the next day after you have been influence of drugs/alcohol?_____ How often does this occur and when is the last time?

_____

Does or has anyone in your family abused drugs or alcohol? _____ Who and to what extent?

_____

_____

Occupational Data

What sort of work are you doing now?

_____

What sort of jobs have you held in the past?

_____

_____

Does your present work satisfy you? _____ If not, what ways are you dissatisfied?

_____

_____

Sex Information

Parental attitudes toward sex (e.g was there sexual instruction or discussion at home?)_____

_____

When and how did you derive your first knowledge of sex? _____

_____

8.

When did you first become aware of your own sexual impulses? _____

_____

Did you ever experience and anxiety or guilt feelings arising out of sex or masturbation? If yes, please explain:

_____

_____

Any relevant details regarding your first or subsequent sexual experience?_____

_____

Is your present sex life satisfactory?_____ If not, please explain: _____

_____

Have you ever experienced any sexual abuse? (*This could include fondling, inappropriate remarks, witnessing adults display sexual behavior, lack of privacy in home, coercion by adults to participate in sexual games, being "checked out" by parents to see if you are developing "properly" or having sex, intrusive touching etc):*

_____ If yes, please state the circumstances and people involved:

_____

_____

Please state what you did about it: _____

_____

Family Data

Husband/wife/partner's age_____

Occupation of husband/wife/partner_____

Personality of husband/wife/partner in your own words: _____

_____

_____

In what areas is there compatibility? _____

_____

_____

In what areas is there incompatibility? _____

_____

_____

How do you get along with your in-laws (This includes brothers and/or sisters-in-law)

_____

_____

_____

How many children do you have?_____ Please list their sex and ages: _____

9.

Do any of your children present special problems?_____ What?_____

_____

Any relevant details regarding miscarriages or abortions? _____

Comments about any previous marriage(s) and brief details: _____

_____

Has there been any physical violence between you and your spouse/partner or child(ren): _____

If so, please explain the circumstances and the action as well as when this occurred: _____

_____

_____

Has there been any verbal violence or abuse in your family?_____ If so, please explain:

_____

_____

How do you and your partner resolve conflicts or differences? _____

_____

_____

_____

Family of Origin Data

Father

Living or deceased? _____ If deceased, your age at the time of his death: _____

Cause of death? _____ If alive, father's present age?_____

Occupation: _____ Health: _____

Mother

Living or deceased? _____ If deceased, your age at the time of her death: _____

Cause of death? _____ If alive, mother's present age?_____

Occupation: _____ Health: _____

Siblings

Number of brothers:_____ Ages: _____

Number of sisters:_____ Ages: _____

Relationship with brothers and sisters:

Past: _____

Present: _____

10.

Give description of your father's personality with his attitude toward you (past and present):

Give description of your mother's personality with her attitude toward you (past and present):

In what ways were you punished by your parents as a child?

Give an impression of your home atmosphere (i.e the home in which you grew up. Mention state of compatibility between parents and between parents and children):

Were you able to confide in your parents? _____ Did your parents understand you? _____

Basically, did you feel loved and respected by your parents? _____

If you have a step parent, give your age when parent remarried: _____

Give an outline of your religious training:

If you were not brought up by your parents, who did bring you up, and between what years?

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc?

Who are the most important people in your life?

Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a "mental disorder"?

What was your greatest challenge or difficulty growing up in your family?

11.

Goals

List the benefits you hope to derive from this therapy: _____

List any situations which make you feel calm or relaxed: _____

Please add any information not tapped by this questionnaire that may aid me in understanding and helping you: