Jennifer Chain, Ph.D.
Psychologist
Thrive for the People, PLLC
License Number PY60750684

Intake Questionnaire

Personal Information

First Name: _____ Last Name: _____

Middle Name: _____ Preferred Name: _____

Email Address: _____ Type of email: ☐ Work ☐ Home
☐ Ok to send me emails

Phone number: _____ Type of phone: ☐ Work ☐ Mobile ☐ Home
☐ Ok to leave voice message ☐ Ok to send text message
☐ Send me text message reminders for appointments

Address:_____

Birthdate: _____ Age: _____ Social Security Number_____

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Gender Queer ☐ Other

Employment status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed
☐ Full-time student ☐ Part-time student ☐ Retired ☐ Homemaker

Emergency Contact Full Name: _____

Relationship: _____ Phone Number: _____
Type of Phone: ☐ Work ☐ Mobile ☐ Home

Demographics/Social History

What pronouns do you use (e.g., she/her/s)?

What is your racial and/or ethnic identity? Please list all that you see fit.

What is your sexual orientation?

What is your religious or spiritual background and/or affiliation?

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To what extent does your religious or spiritual identity play an important role in your life?
☐ Very important ☐ Important ☐ Neutral ☐ Unimportant ☐ Very unimportant

Do you have a disability? If so, please describe.

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others, with family, etc...

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Are you currently involved in a lawsuit? If so, please describe.

Presenting Concerns

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

How long have you struggled with the current issues for which you are seeking counseling?

What are your goals for counseling?

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How ready are you to work on addressing the issues that brought you into counseling? Please check the one that applies to you.

- ☐ I do not think there is an issue
- ☐ I acknowledge that there is an issue but I feel ambivalent about change
- ☐ I acknowledge that there is an issue and I feel ready to take action
- ☐ I have taken actions to change and I am looking for ways to maintain my gains

Referral Source

How did you hear about me? Check all that applies:

- ☐ Google
- ☐ Psychology Today
- ☐ Primary Care Provider: Name_____
- ☐ Another Therapist: Name_____
- ☐ Friend or Family: Name_____
- ☐ Other
  Please describe: _____

Mental Health and Medical History

Have you seen a mental health professional before? If so, provide the name(s) of your therapist, what you sought treatment for, how long the treatment lasted, and when the treatment ended.

If you have been in counseling before, what was helpful about your last therapist? What was not helpful?

List all medications and supplements you are taking presently, when you began taking them, dosage, and for what reason.

Name of Medication	Date Began Taking	Dosage	Condition Being Treated

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If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol? ☐ Yes ☐ No If yes, describe type, amount, frequency:

Do you use recreational drugs? ☐ Yes ☐ No If yes, describe type, amount, frequency:

Do you have suicidal thoughts? ☐ Yes ☐ No If yes, please describe:

Have you ever attempted suicide? ☐ Yes ☐ No If yes, please describe:

Have you ever purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)? ☐ Yes ☐ No If yes, please describe:

Do you have thoughts or urges to harm others? ☐ Yes ☐ No If yes, please describe:

Have you experienced trauma? ☐ Yes ☐ No If yes, please check all that applies:

- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Unwanted sexual experience(s)
- ☐ Significant loss(es)
- ☐ Life-threatening experience(s)
- ☐ Other
  Please describe:_____

Have you ever been hospitalized for a psychiatric issue? ☐ Yes ☐ No If yes, Please describe, where, when and why:

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Is there a history of mental illness in your family? If so, please provide details.

Please check any of the following you have experienced in the past six months:

- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Trouble concentrating
- ☐ Difficulty sleeping
- ☐ Excessive sleep
- ☐ Low motivation
- ☐ Isolation from others
- ☐ Fatigue/low energy
- ☐ Paranoid thinking
- ☐ Problems in relationships
- ☐ Problems with addiction
- ☐ Chronic pain and/or illness
- ☐ Identity concerns
- ☐ Family conflict
- ☐ Work/school problems
- ☐ Other
  Please describe:
- ☐ Low self-esteem
- ☐ Depressed mood
- ☐ Tearful or crying spells
- ☐ General anxiety
- ☐ Fear
- ☐ Hopelessness
- ☐ Panic
- ☐ Binge eating food
- ☐ Irritability
- ☐ Poor judgment
- ☐ Compulsive behavior
- ☐ Frequent worry
- ☐ Guilt/shame
- ☐ Body image concerns
- ☐ Social anxiety
- ☐ Death of a loved one
- ☐ Restricting food
- ☐ Purging food
- ☐ Spiritual concerns
- ☐ Concerns about health
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Harassment
- ☐ Poor impulse control
- ☐ Memory problems
- ☐ Drug or alcohol concerns
- ☐ Physical or sexual assault
- ☐ Racing thoughts
- ☐ Mood swings
- ☐ Peer conflict
- ☐ Cultural adjustment
- ☐ Sexual problems

What else would you like me to know?

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