Northwest Behavioral
Client Intake Questionnaire

CONFIDENTIAL CLIENT QUESTIONNAIRE

If you have a concern or question about any item please feel free to leave it blank until you speak with the counselor.

Today's Date:_____ **Referral Source:** _____

Your Name: _____ **Gender**: Male _____ Female _____

Date of Birth: ___/___/___ **Age:** _____ **Cell Phone#:** _____

Mailing Address: _____ **Home Phone #:** _____

_____ **Work Phone #:** _____

If we need to contact you by phone, which of the above numbers can we leave a confidential voice mail or messages?

Name of emergency contact: _____**Phone#:** _____

Are you employed? : _____ **Your employer:** _____ **Job title**: _____

Are you in school? : _____ **Where:** _____ **Grade:** _____

Insurance Information *(a copy of your card would be helpful)*

Insurance Company: _____ **ID#:** _____ **Group#:** _____

Subscriber's (policy holder) name: _____ **DOB:** _____

Their relationship to you: _____ **Do you have a secondary insurance?:** _____

Secondary Ins. Company: _____ **ID#:** _____ **Group#:** _____

Subscriber's (policy holder) name: _____ **DOB:** _____

Their relationship to you: _____

Education/Family

Years of Education (K-12) ____ **College/Vocational Course of Study?**_____ **Degree/ Certs**._____
Are you a veteran of the Armed Forces? ___Yes ___No **Year Enlisted:** _____ **Year Discharged**:_____
Marital / Relationship status (single, married / partnered, separated, divorced, other) _____
Name of Spouse/Significant Other_____ **Length of relationship**_____ **Length of separation**_____

Children / Step Children:

Name: _____ Age: _____ Relation: _____ Lives Where_____
Name: _____ Age: _____ Relation: _____ Lives Where_____
Name: _____ Age: _____ Relation: _____ Lives Where_____
Name: _____ Age: _____ Relation: _____ Lives Where_____

Health:
Your Primary Care Physician's Name: _____ **Phone #:** _____
How many times have you consulted your physician in the past year? _____ **Regarding**: _____

How would you describe your physical health today? ___Very Poor ___Poor ___Average ___Good ___Excellent
How would you describe your emotional health today? ___Very Poor ___Poor ___Average ___Good ___Excellent

___Yes ___ No Have you experienced any medical problems that you would want us to know about?
___Yes ___ No Have you consulted another mental health professional in the past year? Their name? _____
___Yes ___ No Are you using any non-prescription (over-the-counter or other) medications?
___Yes ___ No Are you currently (or in the past year) using any prescription medication?

List below the names of prescription and non-prescription drugs you are taking now.

1. _____ Dosage _____ Prescriber _____
2. _____ Dosage _____ Prescriber _____
3. _____ Dosage _____ Prescriber _____
4. _____ Dosage _____ Prescriber _____
5. _____ Dosage _____ Prescriber _____

Do you experience any of the following?

___ Difficulty sleeping	___ Excessive worry	___ Increased crying	___ Muscle spasms
___ Headaches	___ Tension under stress	___ Increase in weight	___ Memory loss
___ Backaches	___ Fatigue	___ Decrease in weight	___ Chest pains
___ Nervousness	___ Increased Irritability	___ Restlessness	___ Dizziness
___ Violent thoughts	___ Suicidal thinking	___ Self-harm	

Alcohol and/or Other Drug Use:
___Yes ___No Do you drink beer, wine or hard liquor? If yes, how often do you use alcohol?
___Daily ___3-5 Days/Week ___Weekends ___1-2 Times/Month ___2-6 Times/Year
What is the longest period of time you've gone without alcohol?_____
What is the longest period of time you've gone without drugs?_____

___Yes ___No Is there a history of alcohol problems in your family?
___Yes ___No Do you have a relative who you consider a heavy drinker?
___Yes ___No Has anyone ever expressed concern about your use of alcohol or drugs?
___Yes ___No Do you use tobacco products?
___Yes ___No Have you experimented with drugs other than alcohol?
Types of Drugs that you have experimented with:_____
Your Age at which you last experimented (or currently using?):_____
___Yes ___No Are drug or alcohol issues one of the primary issues you want to discuss today?

Life/Work/Relationships:
___Yes ___No I exercise regularly.
___Yes ___No Generally, I feel rested when I awaken in the morning.
___Yes ___No I am often depressed or moody.
___Yes ___No I am concerned about my family relationships.
___Yes ___No I am concerned about my career development.
___Yes ___No I have more conflicts with co-workers or supervisors than I want.
___Yes ___No Were you mistreated as a child? Is this an issue you want to discuss today? ___Yes ___No
___Yes ___No Sometimes I have difficulty remembering events of the previous day.
___Yes ___No I feel more isolated or lonely now than in the past.
___Yes ___No Have you ever had your driver's license suspended or revoked?
___Yes ___No Have you been in a physical fight since you were 18 years old?
___Yes ___No Have you ever been arrested?
___Yes ___No I have at times become so frustrated or angry that I physically struck another person or object.
___Yes ___No I sometimes wake up during the night feeling restless.

Sleep
How long does it take you to fall asleep? _____ How many hours of sleep per night feels good for you?_____
How many hours of sleep have you been getting per night lately?_____

What would you like to accomplish with your Counselor?
_____
_____
_____
_____