JOYCE D SCHERDIN, MSC,
Licensed Marriage & Family Therapist
Mobile (502) 396-0087

Client Intake Questionnaire

This confidential information data form should be completed for each individual who will be attending counseling. Complete this form carefully and completely. Use the back for any additional information.

GENERAL INFORMATION

Name_____ Today's Date_____

Phone No _____ Phone No _____

Address _____

Occupation_____

Place of Employment_____

Highest Level of Education _____ Degree_____

Gender M F Date of Birth _____/_____/_____ Age _____

Race/Ethnic _____ Country of Origin_____

Social Security No _____

Military History_____

Relationship Status (circle one) Single Dating Engaged Married Separated Divorced Widowed

Length of Time _____ Number of Marriages _____

Emergency Contact (Name, Phone & Relation) _____

Referral Source_____

HEALTH INFORMATION

Primary Physician (Name & Phone number)_____

_____Date of last visit_____

List Medications & dose_____

Recent weight changes _____

Describe your current physical health_____

Have you seen a psychiatrist before? Yes ____ No____ When_____

Please list any significant issues with sleep, food, drugs, alcohol, and medication

_____

_____

Hospitalizations (When/Why)_____

SPIRITUAL INFORMATION

Supportive Faith Beliefs _____

Faith affiliation_____

Current involvement_____

Do you believe in God? Yes____ No____ Uncertain_____ Unimportant_____

Significant changes in your spiritual experience?_____

How your Spiritual situation impacts your need for therapy?

_____

_____

RELATIONSHIP INFORMATION

Spouse‘s Name_____Phone_____

Address (if different from yours)_____

City_____ State_____ Zip Code_____

Place of Employment_____Occupation_____

Gender M F Date of Birth_____ Age_____ Nationality_____

Spouse’s Education Level_____

Date of Marriage_____ Where_____

How old were you both when you married? Husband_____ Wife_____

Previous marriage(s)? How did they end? Dates of marriage?

_____

_____

List children from the marriage(s). Use the last page for additional information or as needed.

Name(s) of children Age Sex Living/Deceased Marital Status

_____

_____

_____

List your current household composition_____

_____

Name of Significant person you are in a committed relationship_____

How long have you known this person_____?

How long have you been committed to this person_____?

Name(s) of children, Age, Sex, Currently live with you?

_____

_____

_____

Are your parents living? Yes___ No___

If no, when and how?_____

Were you raised by someone other than biological parent(s)? Yes_____ No_____

If yes please explain_____

Are your parents married? If no, when did the marriage end and how? _____

Do you have a step parent(s)?_____

Describe your parents' relationship_____

_____

Describe your childhood _____

_____

_____

List siblings in birth order (include yourself) Name Sex Age Living/Deceased Marital Status Children

_____

_____

_____

_____

_____

COUNSELING NEEDS

What are your concerns that bring you into counseling?_____

_____

List any symptoms you are experiencing that are related to these concerns_____

_____

What do you hope to change as a result of our counseling work?_____

_____

Please use the remaining space to communicate additional information not covered in this form.

_____

_____

_____

_____