Michael F. Shea, LICSW, LLC
2311 M Street, NW, Suite 304
Washington, DC 20037
202-966-0575

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note information provided on this form is protected under HIPPA and is confidential information.

Personal Information

Name: _____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____City _____ State _____ Zip _____
Home Phone: _____ May we leave a message? □ Yes □ No
Cell Phone: _____ May we leave a message? □ Yes □ No
Work Phone: _____ No messages will be left at this number.
Email: _____@_____ May we leave a message? □ Yes □ No

****Please note: Email correspondence is not considered to be a confidential medium of communication.***

DOB: _____/_____/_____ Place of Birth: _____ Time of Birth: _____ AM/PM
Time Zone: _____ Age: _____ Gender: _____ Race: _____

Emergency Contact: _____ _____ _____
Name (Please Print) Relationship Phone Number

Current Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____

On a scale of 1-10, (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

Are you currently employed? □ No □ Yes
If yes, what is your current employment situation? _____
_____

Do you enjoy your work? □ No □ Yes
Is there anything stressful about your current work? _____
_____

Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief: _____

Education: (circle highest grade completed) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20+

Degree/Major_____ School (if currently a student) _____

Referred by: (if any): _____

Mental Health History

1) Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.?) □ No □ Yes, previous therapist/practitioner: _____

2) Have you ever been prescribed any psychiatric medication/s? □ Yes □ No
If yes, please list medication and dates prescribed: _____
_____

3) Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes
If yes, for how long? _____

4) Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____
_____

5) What significant life changes or stressful events have you experienced recently? _____
_____

General Health Information

1) How would you rate your current physical health? (Please circle one)
Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very good
Please list any specific health problems you are currently experiencing: _____
_____

3) Are you currently taking any prescription medication/s? □ Yes □ No
If yes, please list: _____
_____
_____

4) How would you rate your current sleeping habits? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:
_____

5) How many times per week do you exercise? _____
What types of exercise do you participate in? _____

6) Please list any difficulties you experience with your appetite or eating problems: _____
_____

General Health Information (continued)

7) Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: _____

8) Do you drink alcohol more than once a week? □ No □ Yes

9) How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Primary Physician: _____ Phone: (_____) _____

Street Address: _____ City: _____ State: _____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g., father, grandmother, uncle, etc.)

	Please Circle	**List Family Member**
Alcohol Abuse	yes / no	_____
Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional Information

1). What do you consider to be some of your strengths? _____
_____

2). What do you consider to be some of your weaknesses? _____
_____
_____

3). What would you like to accomplish during your time in therapy?
_____
_____