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: _____

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 psychiatric medication? □ 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 approximately 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 generally exercise? _____
What types of exercise do you participate in? _____
_____

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

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

General Health Information (continued)

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?
_____
_____
_____

Nature and Risks of Therapy

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Fees:

I understand that I am responsible for my fee payment at the end of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I will be supplied with a statement, following each session, which may be submitted for possible insurance reimbursement.

Initial Consultation (60 minutes)	$ 180.00
Individual Sessions (50 minutes)	$ 165.00
Couples Sessions (50 minutes)	$ 210.00
Family Sessions (50 minutes)	$ 260.00
Group Sessions (75 minutes)	$ 100.00
Intervention Services (60 minutes)	$ 340.00

Cash, check and all major credit cards are accepted for payment.
There is a $30.00 service charge for returned checks.

The fee schedule is reviewed annually, at the end of each year. You will be notified 30 days in advance of any fee increase/s. Currently no fee will increase more than $ 10.00 annually.

Cancellation Policy:

Additionally, I am aware that a scheduled appointment may be cancelled up to 10 minutes prior to the appointment. There will be no charge for the cancelled appointment providing all of the following are met:

- Another appointment is scheduled within 1 week of the original appointment.
- The rescheduled appointment is not cancelled or results in a no-show.

If I do not keep the rescheduled appointment it will be necessary to charge the normal established fee for sessions for this appointment.

Informed Consent

I hereby acknowledge that this information given to **Michael F. Shea, Licensed Clinical Social Worker, (LICSW)**, is true and complete to the best of my knowledge. This information is confidential and is to be released to another person or agency only with my written specific authorization. What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without my written consent or the written consent of my legal guardian.

Termination of Therapy

Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, to schedule and attend a termination session and any balance will need to be addressed prior to termination.

Having read and understood the nature and risks of therapy, the alternatives to treatment, the qualifications and values of the counselor, the nature of the fees and policies regarding cancellations, the limits to confidentiality, the right to terminate therapy, and the right to voice a grievance;

I hereby consent to treatment by Michael F. Shea, LICSW.

My signature on this form verifies my understanding of these conditions. I have received a copy of the HIPPA Notice of Privacy Practices.

X

Client/Guardian Signature **Date**

Guardian Relationship to Client: