The Office of Amanda Medina, MA
Licensed Marriage & Family Therapist

Individual Intake Questionnaire

Name _____ Date_____
Address _____
Home Phone _____Cell Ph_____ Work Ph _____
Where may I contact you at? _____
Age _____ Date of birth _____ Ethnic Background _____
Referred by _____
Emergency contact information _____
Highest Education Level _____ What did you study? _____
Currently in School? _____ Where? _____ Studying? _____
Employer _____ Occupation_____
Length of employment _____ Any problems? _____
Spouses Employer _____
Annual household income _____ Do you own or rent? _____

What issues/concerns cause you to seek treatment? Please describe. _____
_____
_____
_____
_____
Do you have any specific goals with regard to your treatment? _____
_____
_____
Have you experienced any of the following symptoms:

____Thoughts of Suicide	____ Work Problems	___ Depression	___Anxiety
____ Relational Problems	____Anorexia/Bulimia	___Harm yourself	___ Trauma
____Problems with intimacy	____School Problems	___ Legal Problems	___ Violence
____ Difficulty with Anger	____ Drugs/Alcohol	____ Sexual/Physical/Emotional abuse	

___Other_____

Family Status

__single ___married ___divorced ___widowed ___cohabitating ___separated How Long?_____
If in a relationship, how would you describe the quality of your relationship? _____

_____

Number of children _____ Names, Gender & Ages _____

_____

Miscarriages? _____ Stillbirths? _____ Abortions? _____ Deaths? _____
Primary support system: _____
Other significant relationships: _____
Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother: _____

_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father: _____

_____

Names and ages of siblings: _____

_____

Step-parents: _____
In-Laws: _____

Health Information

Have you ever been diagnosed with a serious illness? Please describe _____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

_____

Do you have a family history of mental, emotional or substance abuse problems? _____

_____

Have you ever received mental health treatment before? _____

Name of Therapist	Dates (from when to when)	Reason

Have you ever participated in one or more psychological tests? _____
If so, name of person(s) that administered psychological tests _____
Have you ever been hospitalized for mental or emotional problems? Describe circumstances _____

_____

Are you currently taking any prescription medications? What and for how long?_____

_____

Prescribed by whom and for what condition?_____
Have you ever taken any medications for a mental or emotional condition? _____
When and for how long? _____
Have you ever attempted suicide? When?_____
Describe the circumstances that led to that attempt _____

_____

_____

Are you currently having any suicidal thoughts? Please describe. _____

_____

Please describe your childhood. _____
Have you ever been subjected to verbal, physical, emotional, sexual abuse? Please describe. _____

_____

Have you ever been a victim of a violent crime? Please describe. _____

_____

Are you currently using any types of drugs besides those prescribed by a doctor? _____
Have you ever? _____
If yes, which drugs and how much? _____

_____

Do you smoke? _____ How much? _____ For how long? _____
Do you drink alcohol? _____

If yes, how much per day/week?_____

Other Information

Are you now or have you ever been involved in a lawsuit? Please describe. _____

_____

Describe the role of religion or spirituality in your life: _____

_____

Describe your interests/hobbies _____

Describe your strengths _____

* Please feel free to attach additional pages with any other information you feel would be helpful for your mental health treatment.

8331 Sierra College Boulevard, Suite 222 ~ Roseville, CA 95661
T 916.474.0248 ~ F 916.746.8634