

Individual Psychotherapy Intake Questionnaire

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Please answer as fully as feels comfortable. You may write “prefer not to answer” and discuss any question in person. Your responses will help us use our time thoughtfully.

1. About You

Legal name

Name you would like me to use

Date of birth _____	Pronouns _____
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Phone _____	Email _____
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Home address

Occupation _____	Employer (optional) _____
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Relationship status / significant relationships

How did you hear about this practice?

2. Emergency Contact and Communication

Emergency contact name _____	Relationship _____
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Emergency contact phone

May I leave a voicemail at the number above?

☐ Yes ☐ No

May I send appointment-related email or text messages?

☐ Email ☐ Text ☐ Neither

Please describe any communication or privacy considerations

3. What Brings You to Therapy

What brings you to therapy at this time?

What would you most like to be different as a result of therapy?

How urgent do your concerns feel today?

☐ Manageable ☐ Moderate ☐ Significant ☐ Overwhelming

What has helped, even a little?

4. Current Experiences

Please mark any experiences that have been significant recently:

☐ Anxiety or worry	☐ Depressed mood
☐ Grief or loss	☐ Relationship conflict
☐ Family concerns	☐ Stress or overwhelm
☐ Sleep difficulties	☐ Changes in appetite
☐ Panic	☐ Trauma reactions
☐ Anger or irritability	☐ Low self-worth
☐ Isolation or loneliness	☐ Work or school concerns
☐ Major life transition	☐ Physical health concerns
☐ Difficulty concentrating	☐ Other

Please describe the concerns you marked, including when they began and how they affect daily life

5. Mental Health and Treatment History

Have you previously received psychotherapy or counseling?

☐ Yes ☐ No

If yes, please describe when, for how long, with whom, and what was or was not helpful

Have you ever received a mental health diagnosis?

☐ Yes ☐ No ☐ Unsure

If yes, please describe

Have you ever been hospitalized or received intensive treatment for mental health concerns?

☐ Yes ☐ No

If yes, please describe and include approximate dates

Please list current and recent mental health professionals, if any

6. Physical Health and Medications

Current medical conditions, significant illnesses, injuries, or surgeries

Current medications and supplements (include dose and prescribing clinician when known)

Allergies or medication sensitivities

Primary care clinician	Phone

Have sleep, appetite, energy, pain, hormones, or other physical changes affected your well-being?

☐ Yes ☐ No

If yes, please describe

7. Alcohol and Substance Use

Please describe your current use of alcohol, cannabis, nicotine, prescribed sedatives/stimulants, or other substances

Have you or others ever been concerned about your use?

☐ Yes ☐ No ☐ Unsure

Have you ever received treatment or participated in a recovery program?

☐ Yes ☐ No

Anything else you would like me to understand about substance use or recovery?

8. Family, Developmental, and Relational History

Please describe the family and caregiving environment in which you grew up

Who are the important people in your life now?

Please note significant losses, separations, moves, cultural transitions, or other formative experiences

Is there a family history of mental health concerns, substance use, suicide, violence, or significant medical illness?

9. Trauma and Safety

You may share only what feels appropriate at this stage. Details are not required on this form.

Have you experienced events or relationships that felt traumatic, frightening, violating, or unsafe?

☐ Yes ☐ No ☐ Prefer not to answer

What would be helpful for me to know now?

Are you currently afraid of or being harmed, threatened, controlled, or stalked by anyone?

☐ Yes ☐ No ☐ Unsure

During the past month, have you had thoughts of suicide or of not wanting to live?

☐ Yes ☐ No

Have you ever attempted suicide or intentionally harmed yourself?

☐ Yes ☐ No

Are you currently having thoughts of harming someone else?

☐ Yes ☐ No

Please explain any Yes response and identify current supports or safety plans

This form is not monitored continuously and is not a crisis service. If you may act on thoughts of harming yourself or someone else, call 911, call or text 988, or go to the nearest emergency department.

10. Identity, Culture, Spirituality, and Accessibility

What identities, cultural experiences, communities, spiritual beliefs, or values are important for me to understand?

Have discrimination, marginalization, privilege, migration, or intergenerational experiences affected your life?

Do you need any disability-related, sensory, language, technological, or other accommodations?

11. Strengths, Resources, and Goals

What strengths, practices, relationships, communities, or sources of meaning support you?

What are your two or three most important goals for therapy?

What helps you feel safe, understood, and able to engage in therapy?

Is there anything else you would like me to know before we meet?

12. Review and Acknowledgment

Please review each statement carefully before acknowledging and signing this form.

I understand that completing this form does not establish an emergency-response relationship and that electronic messages may not be reviewed immediately.

☐ I acknowledge

I understand that confidentiality and its limits, fees, cancellation policies, telehealth practices, and other informed-consent matters will be provided separately and discussed with me.

☐ I acknowledge

To the best of my knowledge, the information I have provided is accurate and complete.

☐ I acknowledge

Client signature / typed name _____	Date _____
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