



# Crossroads Counseling and Wellness

## CLIENT INTAKE QUESTIONNAIRE

Please fill in the information below in time for your first session.

### Personal Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ CHP# \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Currently in **School** (*circle one*) Yes No If Yes, where \_\_\_\_\_

**Highest Education Level** Grade \_\_\_\_\_  College  Postgraduate

**Employment**  Part Time  Full Time **Satisfaction (1-10)** \_\_\_\_\_

**Place of Employment** \_\_\_\_\_

**Marital Status**  Never Married  Domestic Partnership  Married  Separated  
 Divorced  Widowed

**Name of Previous Therapist/Psychiatrist?**  N/A  Yes \_\_\_\_\_

**Previous Diagnosis** \_\_\_\_\_

Are you currently taking any **prescription medication**?  Yes  No If yes, please list:

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1. How would you rate your **current physical health**? *(Please tick one)*

Poor  Unsatisfactory  Satisfactory  Good  Very good

2. How would you rate your current **sleeping habits**? *(Please tick one)*

Poor  Unsatisfactory  Satisfactory  Good  Very good

Please list any specific sleep problems you are currently experiencing:

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3. How many times per week do you **exercise**? \_\_\_\_\_

4. Please list any difficulties you experience with your **appetite or eating problems**:

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5. Are you currently experience **overwhelming sadness, grief or depression**?

No  Yes Approximately how long? \_\_\_\_\_

6. Are you currently experiencing **anxiety, panic attacks or have any phobias**?

No  Yes When was your first experience of anxiety attacks?

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7. Are you currently experiencing any **chronic pain**?

No  Yes If yes please describe:

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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

10. 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? \_\_\_\_\_

11. What **significant life changes or stressful events** have you experienced recently?

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**12.** Do you consider yourself to be **spiritual or religious?**  No  Yes

If so, please describe \_\_\_\_\_

**13.** What do you consider to be some of your **strengths?**

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**14.** What do you consider to be some of your **weaknesses?**

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**15.** What would you like to **accomplish** out of your time in therapy?

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### 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.)

Alcohol/Substance Abuse	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____
Depression	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____
Domestic Violence	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____
Eating Disorders	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____
Obesity	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____
Schizophrenia	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____
Suicide Attempts	<input type="checkbox"/> Yes/No <input type="checkbox"/>	_____

# Consent for Treatment and Limits of Liability

## **Limits of Services and Assumption of Risks:**

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.

## **Limits of Confidentiality:**

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 your written consent or the written consent of your legal guardian. The following is a list of exceptions:

### **Duty to Warn and Protect**

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threaten or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

### **Abuse of Children and Vulnerable Adults**

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

### **Prenatal Exposure to Controlled Substances**

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

### **Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

### **Insurance Providers**

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

*By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.*

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**Client Signature** (Client's Parent/Guardian if under 18)

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**Date**

## Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

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**Client Signature** *(Client's Parent/Guardian if under 18)*