Hélène Bélanger
Licensed Clinical Professional Counselor

Client Information - Individual

The purpose of this questionnaire is to obtain some information about you so that I can better serve you. Completing this questionnaire as fully and as accurately as you can, will facilitate the effectiveness of your therapy. It is understandable that you may be concerned about what happens to this information about you, because this information is highly personal. As explained in the Informed Consent document, all material in your file is strictly confidential. If you prefer not to answer any question, just write: N/A (No Answer or Not Applicable). If you need extra space, please use the reverse side.

Contact Information

Client

Name: _____ Date of Birth: _____

Address: _____

Phone _____ Permission to leave message? ____ Yes ____ No

Emergency Contact Name: _____ Phone: _____

Email: _____

Employer and Occupation: _____

Insurance

Insurance Name: _____ Policy #: _____

Co-pay Amount: _____

Responsible Party

Please fill out this information if the Insurance is provided by someone other than the Client.

Name: _____ Date of Birth: _____

Address: _____

Phone _____ Permission to leave message? ____ Yes ____ No

Intake Form

Please describe the concerns for which you are seeking help, including how long you have had these concerns:

_____

_____

Please indicate if you are experiencing problems in any of the following areas:

- ☐ Depressed mood
- ☐ Stress
- ☐ Anxiety/Worry
- ☐ Drug/Alcohol
- ☐ Career
- ☐ Lack of Meaning
- ☐ Anger Management
- ☐ Fears/phobias
- ☐ Hopeless
- ☐ Irritability
- ☐ Mood swings
- ☐ Sadness/crying
- ☐ Other:

- ☐ Health (Sleep, Physical Problems)
- ☐ Eating Issues
- ☐ Body Image
- ☐ Relationships issues
- ☐ Family Issues/Parenting
- ☐ Hallucination or Delusions
- ☐ Change in eating habits
- ☐ Difficulty concentrating
- ☐ Impulsivity
- ☐ Isolating oneself from others
- ☐ Nightmares
- ☐ Significant change in weight
- ☐ Other:

- ☐ Unwanted Sexual Experiences
- ☐ Traumatic Experiences
- ☐ Thoughts of Harming Myself
- ☐ Thoughts of Harming Others
- ☐ Grief
- ☐ Compulsions
- ☐ Decreased motivation
- ☐ Hyperactivity
- ☐ Low self-esteem
- ☐ Panic attacks
- ☐ Physical, sexual, emotional abuse
- ☐ Extremely, excessively busy
- ☐ Other:

Have you been having suicidal thoughts? ___ Yes ___ No

Have you ever attempted suicide before? ___ Yes ___ No

List any other problems you've been experiencing: _____

Has anyone referred you? If so, who? _____

If you have seen a therapist or psychiatrist in the past, please indicate when, with whom, and for what? How successful was it?

_____

_____

Do you have a history of or are you currently experiencing any medical problems?

_____

_____

Please list below along with any medication, including herbal/vitamin supplements you are taking:

_____

_____

Primary Physician: _____

Psychiatrist: _____

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Early life history can also be useful in my work with you. Answer the following questions to the best of your knowledge:

Did your birth mother experience any of the following during her pregnancy/ delivery of you?

- ☐ Pregnancy issues
- ☐ Delivery concerns
- ☐ Low birth weight
- ☐ History of abuse
- ☐ Mother drug/alcohol use
- ☐ Premature
- ☐ Adoption
- ☐ Other:_____
- ☐ Parents divorced/separated
- ☐ Domestic Violence (abuse)
- ☐ Frequent moves
- ☐ Other:_____

Who did you grow-up with? (Biological/adoptive parents, step-parents, foster parents, aunts, uncles, parents of friends etc.)

_____

_____

Who do you live with and what are the relationships and living conditions like?

_____

_____

_____

Do you have a romantic relationship? What is it like? What are your other relationships like?

_____

_____

_____

What is your history with alcohol and drugs? What role does it currently play in your life?

_____

_____

_____

_____

Give details of family members with mental health and substance issue.

_____

_____

Any additional information you may think would be useful for me to know:

_____

What are your strengths? And, how have you coped effectively with your problems?

_____

_____

What are your goals for counseling?

_____

_____

_____ _____

Signature Date

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