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 as confidential information.

Personal Information

Name:____ Date: _____________________
Parent/Legal Guardian (if under 18): ____
Address: ____
Home Phone: ___ ______________________________ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: ________________________ May we leave a message? □ Yes □ No
Email: _______________________________________ May we leave a message? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____________________________ Age: _______ Gender: ________________
Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Husband's or Partner's Name and Number ____

Emergency Contact Name and Number ____

Referred By (if any): ____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: ____

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

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:
____
____

General and Mental Health Information

1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: ______________________

____

2. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
____
____

3. How many times per week do you generally exercise? ________________________________
What types of exercise do you participate in? ____

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

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____

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? _____________
____
____

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.)

		List Family Member
Alcohol/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. Are you currently employed? ◻ No ◻ Yes

If yes, what is your current employment situation? ____
____

Do you enjoy your work? Is there anything stressful about your current work? ___________________
____
____

2. Do you consider yourself to be spiritual or religious? ◻ No ◻ Yes

If yes, describe your faith or belief: ____
____

3. What do you consider to be some of your strengths? _____________________________________
____
____
____

4. What do you consider to be some of your weaknesses? ___________________________________
____
____
____

5. What would you like to accomplish out of your time in therapy? ___________________________
____
____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

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

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____
Print Client Name

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

____
Today's Date

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

____

Print Client Name

____

Client Signature (Client’s Parent/Guardian if under 18)

____

Today’s Date

Hava Schaver, Ph.D

26111 West 14 Mile Road
Suite 200C
Franklin, MI. 48025
Phone: 248-790-4282

CONSENT FORM

I acknowledge that I am voluntarily authorizing treatment for myself, or for my dependent _______________ by Hava Schaver, Ph.D.

I have been informed of the purposes of treatment, the services which may be provided, and any attendant benefits, risks and/or consequences. (I understand that if the treatment is for substance abuse, parental permission is not required for the treatment of a minor.)

____
Print Client Name

_______________________________ _______________
Client's signature Date

_______________________________ _______________
Parent or Guardian Date