EXCEL SOCIAL SERVICES, INC.

480.331.5002 www.excelsocialservices.com

**Adult Demographic Information**

Date: _____

Client Name: _____ DOB: _____ Age: _____

Residential Address: _____ City: _____ Zip: _____

We can send billing/treatment information to this address? ☐Yes ☐No

Home Phone: _____ Massages ok? ☐Yes ☐No

Cell Phone: _____ Massages ok? ☐Yes ☐No

Other Phone: _____ Massages ok? ☐Yes ☐No

Relationship Status: ☐ Single ☐Married ☐Committed Relationship ☐Divorced ☐Separated ☐Widowed ☐Other

Emergency Contact Name #1: _____ Relationship to you: _____

Home Phone: _____ Other: _____

Emergency Contact Name #2: _____ Relationship to you: _____

Home Phone: _____ Other: _____

Referred by: ☐Physician ☐Friend ☐Google Ad ☐Website ☐Other _____

I give permission to receive messages via: ☐Email ☐Text ☐Phone

Client Signature: _____ Date: _____

**Intake Questionnaire**

Client Name: _____ DOB: _____ Age: _____

What brought you into therapy today? _____
What do you wish to change or accomplish as a result of therapy
_____
_____
Have you been in therapy before? ☐Yes ☐No If yes, please state
When: _____ Where: _____

Was it a positive experience? ☐Yes ☐No. What did you like or not like about it?
_____
_____

| **Reflecting on the last 6 months, please check all that apply:** | |
|---|---|
| ☐Frequently sad or depressed | ☐Feel more talkative than usual |
| ☐Feeling restless or keyed up | ☐Excessive spending/shopping |
| ☐Overwhelming worries | ☐Feeling excessive guilt or shame |
| ☐Restless unsatisfying sleep | ☐Unable to relax |
| ☐Difficulty falling asleep or staying asleep | ☐Excessive gambling |
| ☐Muscle tension | ☐Lack of appetite/increased appetite |
| ☐Unable to concentrate | ☐Easily distracted by unimportant things |
| ☐Mood swings | ☐Loss of interest in activities/hobbies |
| ☐Significant change in weight | ☐Take too many risks |
| ☐Decreased need for sleep (only need 3-4 hours) | ☐Feeling hopeless |
| ☐Difficulty motivating | ☐Startle easily |
| ☐Troubling thoughts about the past | ☐Nightmares |
| ☐Withdrawn/isolating self | ☐Troubling thoughts about the past |
| ☐Too neat and orderly | ☐Crying easily/often |
| ☐Low energy level/fatigue | ☐Feeling worthless |
| ☐Difficulty making decisions | ☐Difficulty finishing tasks |
| ☐Repeating certain behaviors over and over | ☐Thoughts to hurt self |
| ☐Easily upset or angered | ☐Stomach aches/vomiting |
| ☐Attempts to harm yourself | ☐Headaches/migraines |
| ☐Thoughts to hurt others | ☐Feeling different from most people |
| ☐Feeling ill/sick | ☐Shy around others |
| ☐Increasing forgetful | ☐Strong fears |
| ☐Use of sedative | ☐Difficulty with work or school |

**Medical History:**

Have you consulted a physician or psychiatrist regarding the problem which brings you here?
☐Yes ☐No If yes, the doctor Name: _____
Are you currently being treated for any medical problems? ☐Yes ☐No
Are you currently taking any medications? ☐Yes ☐No

| Dosage | Type | For (i.e. depression) | Prescribed by |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently taking over the counter medications, herbs or supplements? ☐Yes ☐No
If yes. List: _____
Are you presently in good health? ☐Yes ☐No
Do you engage in physical activity? ☐Yes ☐No If yes, what activity?
_____ How often? _____
Do you smoke cigarettes (cigars, chew)? ☐Yes ☐No #_____ per day
How much alcohol do you drink? #_____ per day _____ # per week
Do you drink caffeinated beverages? ☐Yes ☐No If yes, how many per day? _____
Do you use illicit drugs? ☐Yes ☐No If yes, how often: _____
what drugs do you use? _____
Have you ever tried to cut down or stop using alcohol/drug? ☐Yes ☐No
Has anyone ever asked you to cut down on your drinking? ☐Yes ☐No

Have you ever been hospitalized for any emotional/mental health condition? ☐Yes ☐No
If yes, List the hospitalizations
When: _____ Where: _____
How long: _____ Treatment: _____

Have you experienced or witnessed a traumatic event? (parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one, etc.) ☐Yes ☐No
Do you have a history of domestic violence? ☐Yes ☐No
Do you have a history of verbal, emotional or physical abuse? ☐Yes ☐No
Do you have a history of sexual abuse or sexual assault? ☐Yes ☐No

| **Support systems:** | |
|---|---|
| Do you have one or two friends that you consider close and feel you can depend on? | ☐Yes ☐No |
| Do you have a religion or spiritual practice that you experience as supportive? | ☐Yes ☐No |
| Do you belong to any social groups or participate in hobbies with People that you enjoy? | ☐Yes ☐No |

| | |
|---|---|
| Is there a family member that you trust and can go to in times of emotional need? | ☐ Yes ☐ No |

| **Family History:** | |
|---|---|
| Have you or anyone in your family, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on. | |
| **Have you or a family member experienced:** | **Indicate Self or which Family Member(s):** |
| ☐ Anxiety | |
| ☐ Learning disorder (ADHD, Dyslexia, etc.) | |
| ☐ Illicit drug use | |
| ☐ Depression | |
| ☐ Bipolar disorder | |
| ☐ Alcohol abuse | |
| ☐ Schizophrenia | |
| ☐ Anger | |
| ☐ Eating disorder | |
| ☐ Phobias | |
| ☐ Hospitalization for Mental health condition | |
| ☐ Attempted or completed suicide | |

| **Please check any of the following areas that you would like to address in therapy:** | |
|---|---|
| ☐ Family | ☐ Parenting |
| ☐ Children | ☐ Career/education |
| ☐ Stress | ☐ Phase of life |
| ☐ Relationships | ☐ Assertiveness |
| ☐ Alcohol or Drug use | ☐ Health problems |
| ☐ Verbal abuse | ☐ Loss or death |
| ☐ Childhood experiences | ☐ Spirituality |
| ☐ Physical abuse | ☐ Sexual abuse |
| ☐ Finances | ☐ Self-esteem |
| ☐ Other: _____ | ☐ Other: _____ |
| ☐ Other: _____ | ☐ Other: _____ |

Is there anything else that you would like me to know? _____
_____
_____
_____

My strengths are: _____
_____

My weaknesses are: _____
_____

**My three (3) goals for therapy are:**

1) _____

2) _____

3) _____

**I know that I am better when:**

1) _____

2) _____

3) _____

**Therapist's Note:** _____
_____
_____
_____
_____
_____
_____
_____
_____

**Diagnosis code:**
_____
_____

Client signature: _____ Date: _____

Therapist Name: _____

Therapist Signature: _____ Date: _____