



**Psychotherapy Health Questionnaire and Intake Form**  
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**303-827-4973**

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_  
(First) (Middle) (Last)

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ May I leave a message? Y  N

Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ May I leave a message? Y  N

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Gender: (optional) Male  Female  Transgendered  Other

Sexual Orientation (optional): Bisexual  Gay/Lesbian  Heterosexual  Uncertain

Marital Status: Single  Married  Divorced  Widowed

Children's Names and Ages: \_\_\_\_\_

Name of Spouse/Significant Other: \_\_\_\_\_

Preferred Time \_\_\_\_\_

What is your primary reason/concern for seeking psychotherapy?

\_\_\_\_\_  
\_\_\_\_\_

Please check the number that describes how urgent you feel your concern is at this time:

1  2  3  4  5  6  7  8  9  10

Not at all Urgent

Extremely Urgent

How do you spend your free time? \_\_\_\_\_

\_\_\_\_\_

What are your present interests, activities, hobbies? \_\_\_\_\_

\_\_\_\_\_

Who are major supports in your life:

Parent(s)  Friend(s)  Sibling(s)  Other

Child(ren)  Relatives  Professional Caregiver(s)

Partner  Sibling(s)  Pet(s)  What kind? \_\_\_\_\_

Friend  Religious/Spiritual Community  \_\_\_\_\_

Please describe your eating habits: \_\_\_\_\_  
\_\_\_\_\_

Please describe your average amount of sleep per night \_\_\_\_\_  
\_\_\_\_\_

**Treatment and Medical History**

Are you currently receiving, or have you previously received services from a counselor/ mental health professional (i.e. psychiatrist, therapist, life coach)? Y  N

If yes, please list provider name, contact information and dates of treatment:

Provider \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Dates of Treatment \_\_\_\_\_

Provider \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Dates of Treatment \_\_\_\_\_

Have you ever been hospitalized for emotional or drug/alcohol treatment? Y  N

If yes, please describe the circumstances of hospitalization:

\_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are currently taking:

\_\_\_\_\_  
(medication) (dose) (how often) ( prescribed by ) (reason prescribed)

\_\_\_\_\_  
(medication) (dose) (how often) ( prescribed by ) (reason prescribed)

\_\_\_\_\_  
(medication) (dose) (how often) ( prescribed by ) (reason prescribed)

\_\_\_\_\_  
(medication) (dose) (how often) ( prescribed by ) (reason prescribed)

Please list any herbal supplements or other non-prescribed meds you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Health Care Provider/Current Physician: \_\_\_\_\_

In case of Emergency Please contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship: \_\_\_\_\_

Your signature below indicates that the above information is truthful and accurate and has been answered to the best of your knowledge. You understand that this information will be held confidential by the therapist and will not be shared.

X \_\_\_\_\_