MARNEL TUCKER, PSY.D
CLINICAL PSYCHOLOGIST

Intake Questionnaire

Client Information

Name: _____

Age: _____

Date of Birth: _____

Home Address: _____

City: _____

State: _____

Zip Code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Permission to contact via email?

☐ Yes ☐ No

How were you referred to our practice?

_____

If referred via the internet, please specify the site:

_____

Preferred voicemail message location:

☐ Home Number ☐ Cell Number ☐ Work Number

Background Information

1. Where did you grow up?

_____

Are your parents alive? ☐ Yes ☐ No

Are you in contact with them? ☐ Yes ☐ No

2. How many siblings do you have?

_____

Please list their names, starting with the oldest, including yourself:

_____

3. Which siblings are you currently in contact with?

_____

4. Marital Status:

☐ Single

☐ Married

☐ Divorced

☐ In a Relationship

How many times have you been married or in long-term relationships?

_____

Please list names of previous spouses/partners:

_____

How many times have you been divorced/separated?

_____

From whom?

_____

5. Who is currently in your life?

_____

6. What family members are you close to?

_____

What family members are you distant from?

_____

7. Do you have children? ☐ Yes ☐ No

How many?

_____

Please list their names and ages, starting with the youngest:

_____

Occupational and Religious Background

8. What is your occupation?

_____

Employment Status:

☐ Full-time

☐ Part-time

9. What is your religion, if any?

_____

10. What are your hobbies?

_____

Support System and Mental Health History

11. Please list those in your support system:

_____

12. Do you have a history of abuse? ☐ Yes ☐ No

What type of abuse have you experienced?

☐ Physical

☐ Verbal

☐ Sexual

☐ Neglect

☐ Domestic

☐ Emotional/Psychological

13. Are you currently in therapy? ☐ Yes ☐ No

If yes, please list your current therapist:

_____

14. Have you had past therapy or psychiatric experiences? ☐ Yes ☐ No

If yes, please list the duration and names of all previous treatment practitioners/psychiatrists:

_____

15. Are you currently under the care of a psychiatrist? ☐ Yes ☐ No

Are you currently on psychiatric medications?

_____

16. Are you currently under the care of a medical doctor? ☐ Yes ☐ No

Are you currently on any medical medications?

_____

17. Have you had any psychiatric hospitalizations? ☐ Yes ☐ No

If yes, please list all hospitalizations and duration:

_____

18. Please list any medical hospitalizations:

_____

19. Have you ever been arrested? ☐ Yes ☐ No

If yes, please list the reason:

_____

20. Do you have any legal problems? ☐ Yes ☐ No

If yes, please list any legal issues:

_____

Symptom Checklist

21. Please check any of the following symptoms that apply to you:

☐ Compulsive behaviors

☐ Anger

☐ Anxiety

☐ Depression

☐ Mood swings

☐ Trauma

☐ Sleep disturbances

☐ Substance use (Alcohol, Drugs)

☐ Relationship problems

☐ Other (please specify): _____

Goals and Therapy

22. Please list any issues or problems not included in the checklist that you would like to address:

_____

23. State the primary reason you are seeking therapy:

_____

24. What goals would you like to achieve in therapy?

_____

25. How long do you see yourself needing to achieve these goals?

☐ 1-3 months

☐ 3-6 months

☐ 6-12 months

26. Why are these goals important to you?

_____

27. Additional comments to help identify problem areas:

_____

28. Who else would you like to include in your treatment?

_____

Signature

Thank you for taking the time to complete this form. Your information will remain confidential.

Client/Parent/Guardian Name (please print): _____

Signature of Client/Parent/Guardian: _____

Date: _____