W. Jaime Moss LMHC, SUDP

Client Intake Questionnaire

Name:_____Date:_____

Date of birth:_____ Email:_____

Address:_____ Zip code:_____

Preferred phone number:_____ May we leave a message? Y N

Alternate phone number: _____ May we leave a message? Y N

Your relationship status: Single In a relationship Married Living Together Divorced Widowed

Employment Status: Employed full time Employed part time Laid off Unemployed Other

Employer:_____ Profession:_____

Emergency contact:_____

Relationship:_____ Primary phone:_____ Alternate phone:_____

Payment Information

Please do not bill insurance/no insurance

Primary Insurance Company_____

Primary Insured: Self Spouse Other **Insurance Co.** _____

Primary Insured's Name _____ Date of Birth: _____

Identification #: _____ Group #: _____

Insurance company address: _____

Visit Co-pay: _____ Authorization needed: Yes No

***Please send a photocopy of the front and back of your insurance card.**

Secondary Insurance Company: _____

Primary Insured: Self Spouse Child Other Name of Primary Insured _____

Identification #: _____ Group #: _____

Insurance company address: _____

Please List household members:

Name	Age	Relationship	Occupation	Lives w/ you?

If divorced, please list residential/visitation schedule with minor children: _____

_____

Please indicate past problems with a "P" and current problems with a "C":

____ Depression
____ Anxiety/Panic
____ Anger/Irritability
____ Agitation/Hyperactivity
____ Memory Problems
____ Obsessive Thinking
____ Family/Relationship Issues
____ Parent/Child Difficulties
____ Sexual/Sexuality Issues

____ Difficulty Making Decisions
____ Sleep Difficulties
____ Eating/Weight Problems
____ Negative Thoughts
____ Phobias/Fears
____ Grief/Loss
____ Substance Abuse
____ Other Addiction Problem
____ Domestic Violence

Please indicate past problems with a "P" and current problems with a "C":
____ Social Withdrawal
____ Frequent Crying
____ Other _____
____ Hallucinations
____ Delusions
____ Abuse/Victimization
____ Other Trauma

Please mark all boxes where the following factors have been present:

Factor	Client	Partner	Children	Mother	Father	Siblings
1. Mental Illness						
2. Health Problems						
3. Divorce/Separation						
4. Death/Suicide						
5. Domestic Violence						
6. Substance Abuse						
7. Legal Involvement/Jail						
8. Physical/Emotional/Sexual Abuse/Other Trauma						

Date of last physical exam: _____ Current health status: excellent good difficulties poor

Name of physician/clinic: _____ phone: _____

Current health problems/concerns: _____

Allergies: _____

Have you ever used medication for mental health or emotional reasons? Please describe: _____

_____

Please list all currently prescribed and over the counter medication (excluding vitamins):

Medications	Dosage	Reason for medication

144 Railroad Ave, Ste 205
Edmonds, WA 98020

jaimemosscounseling@gmail.com
206.456.4498

Please list previous mental health and substance abuse treatment: _____

_____

Describe your strengths: _____

Thank-you.

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