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FOR OFFICE USE ONLY:

CLIENT INTAKE QUESTIONNAIRE

Name.....

Date.....

Please take the time to respond carefully and clearly to the following questions as your answers will provide important information in creating your treatment plan. While we realize that we are asking for a lot of information in the forms and questionnaires you are asked to fill out, and that the process can be time consuming, it is the most efficient and cost-effective way to do it.This form will be kept out of your business folder, and will be kept confidential. If there is information you are uncomfortable writing down, it is ok to refrain from doing so. You can discuss this with Dr.Vieille.

■ MAIN PURPOSE FOR SEEKING THERAPY

Please give a brief summary of the condition or conditions, their onset and development.....

What are your main goals for therapy?.....

How will you know when your treatment is complete?.....

List the current major stressors in your life:.....

What major changes or events have occured in your life in the past few years? *(Work, relationships, family, children, financial, etc.)*

Please describe previous treatments *(other therapists, professionals, treatment types)* you have employed for this condition. Please include what you found useful and what was not useful. .....

Please list in order of importance the condition(s) for which you are seeking treatment.

Please rate the severity of the condition(s) according to this scale:

1 = Mild.....the problem is just noticeable
2 = Moderate.....the problem is annoying
3 = Severe.....the problem interferes with daily life
4 = Extreme.....the problem is often debilitating

FOR OFFICE USE ONLY:	
MID-TREATMENT DATE	POST-TREATMENT DATE
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.....	.....
.....	.....

	Condition(s)	# of times per week	Severity
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....

How long have you had this condition(s)? Place condition # 1, 2 or 3 in appropriate time frame.

☐ Less than 6 months ☐ 1 year to 3 years ☐ 6 years to 10 years
☐ 6 months to 1 year ☐ 3 years to 6 years ☐ More than 10 years

What kind of treatment have you received for this condition?

☐ Medical ☐ Surgery ☐ Accupuncture ☐ Accupressure
☐ Nutritional Counseling ☐ Psychotherapy ☐ Hypnosis ☐ Other.....

■ HISTORY OF MEDICATIONS

Are you taking any medications? If yes, name and phone number of Physician .....

Please list any medication(s) you are currently taking for the condition(s):

Name of Drug	Dosage per day (Amount/Time)	Usefullness	For how long

List other medication(s) you have taken in the past for the condition(s):

What, besides medication, generally makes the condition(s) better?.....

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What generally makes the condition worse?.....

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How long does the condition usually last? Hours..... Days.....

■ ☐ Left Handed ☐ Right Handed

■ GENERAL MEDICAL HISTORY

Past Medical Problems? *(Illnesses, chronic conditions, allergies, etc.)* Please explain: .....

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Have you ever had surgery OR been hospitalized for any reason? ☐ Yes ☐ No If yes:

Reason ..... Surgery .....

When ..... Hospital .....

Treating Physician .....

Phone # .....

Have you ever had any trauma to the head? *(Falls, concussions, etc.)* ☐ Yes ☐ No If yes, please give pertinent details.

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Do you have a history of seizures? ☐ Yes ☐ No If yes, please explain. .....

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■ ALCOHOL AND DRUG HISTORY

Please list the types of substances used, age you started and duration of use, and how they made you feel, and what benefit you got from them. List current use. Include alcohol, marijuana, pills, inhalants, cocaine, speed, opiates, steroids, barbiturates, and hallucinogens, etc. .....

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Family history of addiction, or alcoholism. .....

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Current caffeine use per day *(include teas, sodas, chocolate, as well as coffee.)* .....

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Nicotine use per day .....

■ CHECKLIST FOR AUTONOMIC NERVOUS SYSTEM ISSUES

- ☐ Headaches
- ☐ Excessive urination
- ☐ Faintness / dizziness
- ☐ Lump in throat
- ☐ Dry mouth
- ☐ Lower back pains
- ☐ Weakness in parts of body
- ☐ Pains in heart / chest
- ☐ Itching
- ☐ Trouble getting breath
- ☐ Shakiness
- ☐ Feeling fearful
- ☐ Difficulty concentrating
- ☐ Overeating
- ☐ Blushing
- ☐ Twitches, tics, spasms
- ☐ Voice quavering / shaking
- ☐ Grinding of teeth
- ☐ Soreness of muscles
- ☐ Heart racing
- ☐ Smoking
- ☐ Nausea / upset stomach
- ☐ Feeling tense / nervous
- ☐ Extreme fear of events
- ☐ Feeling inferior / low self esteem
- ☐ Thoughts hard to get rid of
- ☐ Constipation
- ☐ Loose bowel movements
- ☐ Hot flashes
- ☐ Stuttering
- ☐ Tightness in jaw
- ☐ Heavy feeling in arms / legs
- ☐ Allergies
- ☐ Tightness in stomach
- ☐ Sweaty palms
- ☐ Extreme fear of places
- ☐ Bad dreams / nightmares
- ☐ Concentration / forgetful
- ☐ Suicidal thoughts
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Fatigue
- ☐ Easily crying
- ☐ Loss of sexual functioning
- ☐ Easily annoyed / irritated
- ☐ Cold hands or feet
- ☐ Hiccups
- ☐ Poor appetite
- ☐ Loss of sexual interest
- ☐ Loss of interest in activities
- ☐ Acid reflux

■ CHECKLIST FOR LIFE ISSUES

Please check any of the following areas which you are having difficulty:

☐ Nervousness	☐ Relationships	☐ Headaches	☐ Family	☐ Anxiety
☐ Shyness	☐ Friends	☐ Memory	☐ Unhappiness	☐ Restlessness
☐ Divorce	☐ Children	☐ Chronic Pain	☐ Work	☐ .....
☐ Drug Use	☐ Irritability	☐ Self-Esteem	☐ Dating Skills	☐ .....
☐ Anger	☐ Isolation	☐ Career Choices	☐ Assertiveness	☐ .....
☐ Relaxation	☐ Depression	☐ Nightmares	☐ Making Decisions	☐ .....
☐ Legal Matters	☐ Boredom	☐ Eating Problems	☐ Concentration	☐ .....
☐ Energy	☐ Alcohol Use	☐ Being a Parent	☐ Health Problems	☐ .....
☐ Loneliness	☐ Self-Control	☐ Fears	☐ Marriage	☐ .....
☐ Education	☐ Stress	☐ Finances	☐ Perfectionism	☐ .....

History of trauma *(Emotional / Psychological. Indicate nature and severity, or discuss with Dr. Vieille.)* .....

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Family history of mental illness, trauma, or abuse. .....

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My Thoughts: *(Describe: For example: I can't stop thinking about…)* .....

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Sudden Change of Mood: .....

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What do you usually do to relieve stress, tension, and anxiety?

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■ Is there anything else you think is important and you would like me to know about? *(If necessary, please attach separate sheet.)* .....

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