Date: _____

AMANDA KRACEN, Ph.D.
LICENSED PSYCHOLOGIST

Welcome! Please complete the following Intake Questionnaire. Leave blank any items that do not apply or that you do not feel comfortable completing. Thank you.

Contact Information

1. Name: _____
2. Preferred name (if any): _____
3. Date of birth: ____/_____/_____
4. Last 4 of SSN: _____
5. Home Address: _____
   _____
   _____
6. Mobile phone: _____
   Ok to leave messages? ☐ Yes ☐ No
7. Work phone: _____
   Ok to leave messages? ☐ Yes ☐ No
8. E-mail: _____
   Ok to leave messages? ☐ Yes ☐ No

Emergency Contact

9. Name: _____
   a. Relation to you: _____
   b. Phone: _____
      ☐ Mobile ☐ Home ☐ Work
   c. Alt. Phone: _____
      ☐ Mobile ☐ Home ☐ Work
   d. Home Address: ☐ Same as client, or:
      _____
      _____
      _____

Education, Work, & Legal History

10. Highest level of education completed:

☐ Grade _____ ☐ GED
☐ High School ☐ Some college
☐ Associate's degree ☐ Bachelor's degree
☐ Master's degree ☐ MD/PhD

☐ Other: _____

11. Current work:

☐ Employed ---------->

a. Employer: _____

b. Job title: _____

c. Hours per week: _____

☐ Student
☐ Work in the home
☐ Not working

12. Legal history: ☐ *None*
☐ Arrested in the past
☐ Convicted of a crime
☐ Involved in litigation currently

Medical Conditions and History

13. Have you had any of the following medical concerns? ☐ *None*

☐ Cancer ☐ Diabetes
☐ Thyroid problems ☐ Concussion
☐ Low iron (anemia) ☐ Seizure/Epilepsy
☐ Head injury or TBI ☐ Migraines
☐ Chronic pain ☐ Other (specify):

_____

14. Do you have a documented or diagnosed disability? ☐ *None*

☐ Deaf or hard of hearing ☐ ADHD or Learning Disability
☐ Visual impairment ☐ Mental health disorder
☐ Mobility impairment ☐ Physical/health-related disorder
☐ Chronic pain ☐ Other (specify):

_____

15. Please list all current medications:

_____

_____

16. Name of your primary care doctor: _____
    a. Practicing at what clinic/hospital? _____
    b. Phone: _____
    c. Approximate date of your last visit: _____

17. Name of your psychiatrist (if applicable): _____
    a. Practicing at what clinic/hospital? _____
    b. Phone: _____

Identity Information

18. Relationship: ☐ Single ☐ Partnered ☐ Married ☐ Separated/Divorced ☐ Widowed
19. Do you have children? ☐ Yes ☐ No Ages: _____
20. How do identify with regard to…
    a. Gender: _____
    b. Race and/or Ethnicity: _____
    c. Sexuality/Orientation: _____
    d. Religion/Spirituality: _____

Mental Health History

21. Have you had previous counseling? ☐ Yes ☐ No
    a. When? _____
    b. For what? _____
    c. Was it helpful? _____
22. Have you ever been to the hospital for mental health concerns? ☐ Yes ☐ No
23. Are you aware of any family history of mental health concerns, even if not diagnosed (e.g., anxiety, depression, substance use, suicides/attempts)? ☐ Yes ☐ No
    a. *If "Yes," please list the relation to you and the type of concern:*

_____

_____

_____

Presenting Concerns

24. What brings you to therapy? Why now?

25. How long has this concern/problem been distressing to you?

26. Who are the primary people you turn to for support?

27. What you do consider to be your strengths?

28. What brings you meaning / purpose in your life?

29. What do you hope to get from therapy?

30. What else should I know about you?

Thank you!