
5014 Chesebro Rd. Ste #4
Agoura Hills, Ca 91301
818-991-4910

Confidential Intake Questionnaire

Today's Date _____

Name _____

Address _____

Home phone _____ Msg OK No Msg

Work phone _____ Msg OK No Msg

Cell Phone _____ Msg OK No Msg

Email _____

Date of Birth _____ Age _____

Marital Status _____ How long? _____

Education Level _____ Occupation _____

Names and ages of children _____

In case of emergency, please contact:

Name _____ Relationship _____

Address _____

Phone: _____

Home

Work or Cell

Occupation _____ Length of employment _____

Employer _____

Annual household income _____

What issues/concerns caused you to seek therapy at this time? _____

Do you have any specific goals with regard to your treatment? _____

Have you ever received mental health treatment before? _____

When? _____ For how long? _____

What was the focus of treatment? _____

Previous hospitalization? ___ Yes ___ No Number of hospitalization? ___ ECT? ___

If yes, When _____

Are you currently taking any prescription medications? _____

List names and dosages _____

Name of prescribing doctor _____

Last Medical Exam: _____

List any medical problems you are experiencing: _____

Who referred you to this office? _____

Signature _____ Date _____