Cameron McIntosh, LMSW
6100 Lake Forrest Dr., Suite 450, Atlanta, GA 30328
cmcintoshtherapy@gmail.com
404-421-4598

Client Questionnaire

This Form is Confidential

Today's date: _______________

Your name: ____
Last First Middle Initial

Date of birth: ____________________________

Home address: ____

City: _______________________________________ **State:** _______**Zip:**__________________

Name of Employer:____

Home Phone: _________________________ **Cell Phone:** ___________________________
Email: ____

Is text communication okay _____ YES _____ NO
Is email communication okay ______ YES _____ NO
Is it okay to leave a voicemail ______ YES _____ NO

Referred by: ____

May I have your permission to thank this person for the referral? _____ YES _____ NO

Person(s) to notify in case of any emergency: ____
Name Phone
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _________________________________

Please briefly describe your presenting concern(s): __________________________________

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What are your goals for therapy? ____

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The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: ______________________

____

____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?____________________

Do you consume caffeine? YES NO If YES, how much per day? ____________________

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? ____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):__________________________

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Previous psychiatric hospitalizations (Approximate dates and reasons):________________________

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Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): ____

____

____

RELATIONSHIPS & SOCIAL SUPPORT:

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_________________________________

Do you have Children?____ If YES, how many and what are their ages:______________________

With whom do you currently live? ____

What do you think are your strengths?____

____

____

AREAS OF CONCERN:

Please place a check mark next to each item which identifies an area of concern to you. Place two checks by those items, which are most important. You may add comments after areas checked.

___ Anger
___ Anxiety
___ Compulsive behavior
___ Depression
___ Domestic violence
___ Education/school problems
___ Eating difficulties
___ Excessive Worry
___ Financial problems
___ Health concerns
___ Impulsive behavior
___ Marital concerns
___ Obsessions
___ Problems with partner
___ Problems with children
___ Problems with parents/other family members
___ Panic
___ History of physical abuse
___ History of verbal/emotional abuse
___ History of sexual abuse
___ Victim of crime or assault
___ Hallucinations/delusions
___ Nightmares
___ Religious/Spiritual concerns
___ Sexual concerns
___ Sexual orientation
___ Thoughts of suicide
___ Thoughts of hurting someone else
___ Unhappy most of the time
___ Use of alcohol/drugs
___ Use of alcohol/drugs by spouse/partner
___ Vocational goals
___ Workplace issues
___ Memories of traumatic event
___ General loss of interest/motivation
___ Infertility
___ Postpartum depression/anxiety/OCD
___ Grief/loss

Any additional information you would like to include:

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