Big Sky Family Therapy

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Family Systems Trauma Therapy Advanced Certificate

DIR/Floortime Advanced Certificate

INTAKE QUESTIONNAIRE

Date :

Client name:

Email : **Phone:** **Text OK ?** Yes

Address:

Who referred you?

Family member ☐
Self ☐
Friend ☐

Physician (Name):

Mental Health Specialist (Name):

Other (describe):

Why are you seeking help? Please be specific as possible; i.e., present depression or loss, anxiety has increased, spouse or partner relationship, past trauma, etc.

How urgent is your need for help? Select one

Please explain if "*Very Urgent*" or "*Extremely Urgent*":

Previous treatments? (including medications): Specify yes or no

If YES, when, who, and what was the focus of treatment?

Previous evaluations and therapies **(please indicate who, when, what reason, the focus in each item below)**

Physician (primary care or specialist)

Psychiatrist or Psychiatric Nurse Practitioner (medication?):

Psychologist or mental health counselor:

Occupational, Physical and Speech/Language Therapists:

Top 3 concerns?

1.

2.

3.

***How have you tried to address these concerns so far*?** (Please describe)

Support people in your life and how do you reach out to them and what do they do for you? (no names)

Qualities and skills which bring you a positive sense of self? (Please describe)

Interests/Hobbies (activities which relax you and bring you pleasure?)

Possible Therapy Goals? (Describe three areas of focus for therapy. Please give reasons why.)

1.

2.

3.

Major or minor things that have happened to you, *recently or in the past*, that may influence your therapy outcomes. (Please indicate if they are major or minor.)

Anything we have not asked about *which may be important and would help us understand you?*
(Examples: culture, religious faith, health status, or anything you want to communicate.)

Your signature: ***Date*** *(mm/dd/yy):*

Your name: