Stacey Neil, MA, LMFT
Marriage Family Therapist Lic. #51986
1-408-827-5139
www.staceyneil.com

INITIAL QUESTIONNAIRE

Filling out this confidential form will help me to have pertinent information to provide you with the best care possible. I thank you in advance for taking the time to do so.

Client Information:

Client Name: _____Nickname: _____

Occupation: _____

Age: _____ Date of Birth: _____ Race: _____

Client Cell Phone: _____ Home:_____

Client E-mail: _____

Preferred Method of Contact by Therapist:_____

Home Address:

_____

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed

Additional Family Members and Other People Living in the Home:

Name: _____
Relationship: _____ Age: _____

Name: _____
Relationship: _____ Age: _____

Name: _____
Relationship: _____ Age: _____

Payment Invoice/Receipt Needed?

Stacey Neil, MA, LMFT does not take insurance, but will provide an invoice for you to submit to your insurance company if requested. Would you like us to prepare a monthly invoice? ___Yes ___No

Emergency Contact Information:

Name: _____
Relationship: _____ Phone #: _____

Presenting Problems:

1. Please state your concerns; specify the nature of the problem, duration, frequency, and severity:

_____

_____

_____

_____

2. How have you been dealing with this problem so far?

_____

_____

_____

3. How do you hope I can be of help?

_____

_____

_____

4. What do you think is a realistic time frame for solving your problem?

_____

_____

Client's Health History:

1. Are you currently under a Physicians care for any chronic health problems? (if yes, please list current health conditions)

_____

_____

2. Have you previously participated in mental health services?

_____

_____

_____

3. Are you currently under the care of a Psychiatrist? If yes, please list:

Psychiatrist Name and Number: _____

Date of Last Visit: _____

Are you currently taking any prescribed medications?
If so, please list out each medication:

Purpose _____
Dose _____
Side Effects (if any)_____

Family History of Mental Illness/Substance Use:

1. Describe any physical or mental illness that runs in the family including depression or suicide:

_____

_____

4. Do you currently, or have you ever used substances such as alcohol or drugs to cope with emotional issues in your life?

_____

_____

To Be Filled Out Only If Client is Under 18

Mother's name: _____ Age: _____

Occupation: _____

Cell phone: _____

Email: _____

Address if different from client:

_____

Father's name: _____ Age: _____

Occupation: _____

Cell phone: _____

E-mail: _____

Address if different from client:

_____

Parent's marital status: ___Married ___Separated ___Divorced ___Widowed

Current custody arrangement (if applicable):

_____

_____

Person responsible for payment if client is a minor:

_____

Thank you for providing this confidential information to benefit your care.