DANAE POWERS M.S.
LICENSED MARRIAGE AND FAMILY THERAPIST

License # MFC 52528
228 East Foothill Boulevard
Arcadia, California 91006-2508
(626) 385-7284
info@danaepowers.com

NEW CLIENT QUESTIONNAIRE

Prior to the commencement of treatment, new clients must complete this form. The information provided by you will be helpful to me in several ways, including, but not limited to, understanding your chief complaints, knowing how you prefer to be contacted, and understanding your mental health and medical treatment history. Acquiring this information is a critical component of an overall intake process and goes hand-in-hand with informed consent. In the same way that you need information from me to determine whether I am the right therapist for you, I gather enough information about you to determine whether you are an appropriate client for me. Please feel free to contact me with any questions you have regarding this questionnaire.

____/____/_____
Date

GENERAL

Name: _____
Last First Middle

Address: _____
Number Street Apt / Unit / Space

_____
City State Zip Code

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Work Phone: (_____) _____-_____ Fax: (_____) _____-_____

Email: _____ Referred by: _____

Age: _____ Date of Birth: ____/____/_____ Occupation: _____

Educational Level:
☐ GED or equivalent ☐ Some College ☐ Bachelors
☐ High School Diploma ☐ Associates ☐ Masters
☐ Doctorate ☐ Certificate/Technical School

Marital Status:
☐ Single (never married) ☐ Registered Domestic Partner
☐ Married ☐ Legally Separated
☐ Divorced ☐ Widowed

Names of Children: Date of Birth:

_____ ____/____/_____

_____ ____/____/_____

_____ ____/____/_____

DANAE POWERS M.S.
LICENSED MARRIAGE AND FAMILY THERAPIST

License # MFC 52528
228 East Foothill Boulevard
Arcadia, California 91006-2508
(626) 385-7284
info@danaepowers.com

EMERGENCY CONTACT INFORMATION

Name: _____
Last First Middle

Address: _____
Number Street Apt / Unit / Space

_____
City State Zip Code

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Work Phone: (_____) _____-_____ Email: _____

Explanation of information to be disclosed to emergency contact in the case of an emergency, including any limitations on information to be disclosed:

_____

_____

FINANCIAL INFORMATION

Should you require financial assistance, referrals for low- to no-cost agencies in the area may be provided. This office accepts cash and money orders only for the first visit.

Gross Annual Household Income: $_____

Living Arrangement: Own / Rent # of Household Members: ____

If planning to use health insurance, please bring card to first appointment*. You will be responsible for the full fee at the start of each session. A "super-bill" will be provided to you monthly to submit to your insurance company for reimbursement.*

Name of Insurance Company: _____

Policy #: _____ Group #: _____

Provider Phone: (_____) _____-_____

AREAS OF CONCERN

What issues/concerns cause you to seek treatment? Please describe in detail.

_____

_____

_____

DANAE POWERS M.S.
LICENSED MARRIAGE AND FAMILY THERAPIST

License # MFC 52528
228 East Foothill Boulevard
Arcadia, California 91006-2508
(626) 385-7284
info@danaepowers.com

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

_____

_____

Do you have any particular concerns/fears with regard to treatment?

_____

_____

MEDICAL HISTORY

An authorization for release of confidential information will be needed so that any applicable former therapist, test administrator, or health care provider may be contacted.

Have you ever received mental health treatment before? Yes / No

Dates of Treatment: ____/____/_____ to ____/____/_____

What was the focus of treatment? _____

_____

Have you ever been subjected to one or more psychological tests? Yes / No

If so, for what purpose? _____

_____

Have you ever been hospitalized for psychiatric reasons? Yes / No

If so, when? _____

Reason for hospitalization(s): _____

_____

Have you ever taken any psychiatric medication? Yes / No

Name of Medication	Reason	Date Originally Prescribed	Dosage(s)
_____	_____	____/____/_____	_____
_____	_____	____/____/_____	_____
_____	_____	____/____/_____	_____
_____	_____	____/____/_____	_____

DANAE POWERS M.S.
LICENSED MARRIAGE AND FAMILY THERAPIST

License # MFC 52528
228 East Foothill Boulevard
Arcadia, California 91006-2508
(626) 385-7284
info@danaepowers.com

Were you compliant with taking the medication(s) as prescribed? Yes / No

Have you had any problems/side effects with a psychotropic medication? Yes / No
If so, please explain: _____

_____

Have you ever heard or seen things that others cannot hear or see? Yes / No

If so, please explain in detail: _____

_____

_____

_____

_____

_____

Have you ever attempted suicide? Yes / No Age(s) at Attempt(s): _____

Please describe the circumstances that led to your attempt(s): _____

_____

_____

_____

_____

Are you currently having any suicidal thoughts? Yes / No

If so, please describe in detail: _____

_____

_____

_____

_____

Have you ever been subjected to childhood neglect or verbal, physical, emotional, or sexual abuse as a child or as an adult? Yes / No

DANAE POWERS M.S.
LICENSED MARRIAGE AND FAMILY THERAPIST

License # MFC 52528
228 East Foothill Boulevard
Arcadia, California 91006-2508
(626) 385-7284
info@danaepowers.com

If so, please describe briefly: _____

_____

_____

_____

Have you ever been in a 12-step program? Yes / No If so, Which? _____
Have you ever attended rehab or been hospitalized due to addiction? Yes / No

Please explain any addiction history: _____

_____

_____

_____

Do you have any medical conditions that may affect your treatment? Yes / No

If so, please explain: _____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Yes / No

If so, please describe: _____

_____

Are you currently taking any prescription medication? Yes / No

Name of Medication	Reason	Date Originally Prescribed	Dosage(s)
_____	_____	____/____/_____	_____
_____	_____	____/____/_____	_____
_____	_____	____/____/_____	_____
_____	_____	____/____/_____	_____

Have you had any problems/side effects with a prescribed medication? Yes / No

If so, please explain: _____

_____

DANAE POWERS M.S.
LICENSED MARRIAGE AND FAMILY THERAPIST

License # MFC 52528
228 East Foothill Boulevard
Arcadia, California 91006-2508
(626) 385-7284
info@danaepowers.com

Do you smoke? Yes / No How much? _____ For how long? _____

Do you drink alcohol? Yes / No

How much do you drink in an average week? _____

Do you currently use, or have you ever used, illegal drugs? Yes / No

If so, please explain: _____

_____

OTHER INFORMATION

Please describe your spirituality: _____

_____

Are you now, or have you ever been, involved in a lawsuit? Yes / No

If so, please explain: _____

_____

Please feel free to include any other information that you believe is relevant to your mental health treatment:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____