***Gift of Psychotherapy*** *Blake Roberts MA, LPC  
Lindsay Roberts MA, LPC  
Licensed Professional Counselor  
2855 N. Speer Blvd., Suite E; Denver, CO 80211  
720-232-0429 (Blake) 609-923-0785 (Lindsay)*

Intake Questionnaire

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ROI Needed? If so, please complete Release of Information page.)

Insurance Carrier (if have):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Please briefly tell me what brings you in today?

• What goals would you like to have when it comes to us working together?

• Have you participated in psychotherapy before? If so, what was beneficial? What was not helpful?

* Have you ever been treated for substance abuse or other addictive behaviors? (if YES, for what)

• How often to you drink alcohol? \_\_\_\_\_\_ per week Smoke \_\_\_\_\_\_ per day

Recreational Drugs \_\_\_\_\_\_

* Have you ever considered or attempted suicide or homicide? YES or NO.
* Did you have a plan? YES or NO. (If yes, please explain.)
* Do you feel suicidal/homicidal now? YES or NO.
* Do you have a family history of suicide/homicide? YES or NO. (If yes, please explain.)
* Have you ever been hospitalized for depression or other emotional distress? (if so, in what year)
* Do you ever hear voices, see things that are not real, have any other hallucinations/delusions (auditory, visual, command, paranoia, etc)? YES or NO. (If yes, please describe.)
* Have you ever been a victim of emotional, physical or sexual abuse? YES or NO.
* Have you experienced trauma or other PTSD symptoms? YES or NO. (If yes, please briefly describe.)
* Do you feel you have difficulty controlling your anger? YES or NO.
* Do you have access to weapons? YES or NO. If yes, what kind?
* Please describe your sleep, appetite, energy level, motivation, mood, issues with ADLs (hygiene).
* Are you experiencing Anxiety or Panic? YES or NO. (If yes, please describe.)

• What individuals make up your support system (those people in your life you have the closest connection with)?

• How would you describe your communication style (passive, aggressive, assertive, pleaser, uses humor to deflect, etc.)

• Do you have any fears about seeing a therapist? If so what are they?

• Anything else you would like to share (family history, attributes, hobbies, general fears, other symptoms not described above, etc)