Abundant Living Counseling and Consultation, PLLC
1923 J N Pease Place, Suite 104 Charlotte, NC 28262
T: 980.999.3212

Client Intake Questionnaire

Please fill in the required information below
Please note: information provided on this form is protected as confidential information.

Personal Information

Name:____ Date: _____________________

Address: ____

Home Phone: ________________________________ May we leave a message? ☐ Yes ☐ No

Cell/Work/Other Phone: ________________________ May we leave a message? ☐ Yes ☐ No

Email: ______________________________________ May we leave a message? ☐ Yes ☐ No

****Please note: Email correspondence is not considered to be a confidential medium of communication.***

DOB: ____________________________ Age: _______ Gender: ________________

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married

☐Separated ☐ Divorced ☐ Widowed

Referred By (if any): ____

Legally Responsible Person (if client is a child) ____
Name Relationship

Emergency Contact Name: __________________________ **Relationship** _____________________

Emergency Contact Telephone #: (   ) ____

Insurance Information (please complete as much as possible)

Name of Primary Insurance Company: ____

Policy ID#: ____

Policy Group#: ____

Employer Name: ____

Policy Holder Name: ____

Relationship to Client: ____________________________ Policy Holder DOB: _____________

Insurance Authorization

I understand that if services are being paid for using insurance, Abundant Living Counseling and Consultation, PLLC will release any and all records pertaining to treatment to the insurance company if such disclosure is necessary for claims processing, case management, coordination of treatment, or utilization review purposes. I hereby authorize payments for medical services rendered to myself to be made either to me or on my behalf to Abundant Living Counseling and Consultation. I understand that I am responsible for any amount not covered by insurance.

Patient Signature: ____ Date: ________________

Legal Guardian Signature: ____Date: _________________

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication? ☐ Yes ☐ No
If yes, please list: ____

____

____

Have you ever been prescribed psychiatric medication? ☐Yes ☐ No
If yes, please list and provide dates:

____

____

General and Mental Health Information

1. How would you rate your current physical health? (Please check one)

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Please list any specific health problems you are currently experiencing:

____

____

2. Do you have a Primary Care Physician or facility? ☐ Yes ☐ No
If yes, please list name, address and date of last appointment:

____

____

3. How would you rate your current sleeping habits? (Please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

____

4. How many times per week do you generally exercise? ______________________________________
What types of exercise do you participate in? ____

____

5. Please list any difficulties you experience with your appetite or eating problems:

____

6. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes
If yes, for approximately how long?____

7. Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes
If yes, when did you begin experiencing this? ____

8. Are you currently experiencing any chronic pain? ☐ No ☐ Yes
If yes, please describe: ____

9. Do you drink alcohol more than once a week? ☐ No ☐ Yes

10. How often do you engage in recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

11. Are you currently in a romantic relationship? ☐ No ☐ Yes
If yes, for how long? ____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
____

12. What significant life changes or stressful events have you experienced recently?
____
____

13. Please describe emotional symptoms that you have been experiencing in the past few weeks (e.g. sadness, irritability, crying/sleep disturbance):

____
____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. mother, father, grandmother, brother, uncle, etc.)

	Please Check	List Family Member
Alcohol/Substance Abuse	☐ yes ☐ no ☐ unknown	______________________
Anxiety	☐ yes ☐ no ☐ unknown	______________________
Depression	☐ yes ☐ no ☐ unknown	______________________
Domestic Violence	☐ yes ☐ no ☐ unknown	______________________
Eating Disorders	☐ yes ☐ no ☐ unknown	______________________
Obesity	☐ yes ☐ no ☐ unknown	______________________
Obsessive Compulsive Behavior	☐ yes ☐ no ☐ unknown	______________________
Schizophrenia	☐ yes ☐ no ☐ unknown	______________________
Suicide Attempts	☐ yes ☐ no ☐ unknown	______________________

Additional Information

1. Are you currently employed? ☐ No ☐ Yes
If yes, what is your current employment situation? ____

____

Do you enjoy your work? Is there anything stressful about your current work? ____________________

____

____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
If yes, describe your faith or belief: ____

____

3. What do you consider to be some of your strengths?

____

____

4. What do you consider to be some of your weaknesses?

____

____

5. What would you like to accomplish out of your time in therapy?

____

____

Authorization for Credit Card Use

It is the policy of this office to keep a credit card on file for all clients in order to ensure payment for services.

I authorize Tanya M. Hughes d/b/a Abundant Living Counseling and Consultation, PLLC to charge the credit card provided below for the following fees if I do not pay them in person when attending treatment:

- Initial Session
- Therapy session
- Late cancellation fees
- No Show/No Cancellation fee
- Returned Check Fee
- Telephone calls between therapy sessions (if longer than 15 minutes), requests for records, or collateral support services.
- Any therapy sessions or other services that are not reimbursed by insurance

I agree to pay for these purchases in accordance with the issuing bank cardholder agreement.

Client Name: ____

Name on Card: ____

Billing Address: ____

____

Credit Card Type: ______Visa _____MasterCard _____ Discover _____ AmEx

Credit Card Number: ____

Expiration Date: _________________

Card Identification Number: __________ (last 3 digits located on the back of the card)

Cardholder Signature: ____

Print Name: ____ Date: _______________

****Receipt will be sent via TherapyNotes via request***