Don Baker, MA, LMHC
1836 Westlake Avenue N - Suite 303A
Seattle, Washington 98109
support@unpackingadhd.com
www.unpackingadhd.com

Client Intake Questionnaire

Thank you for taking the time to complete this intake form. Your responses here will help me to get to know you better prior to our first session. Please note that this information with be kept confidential.

I look forward to working with you soon!

Don

Demographics

First Name:

Last Name:

Address:

City:

State/Province:

Zip/Postal Code:

Country:

DOB:

Email:

(**Note:** Email correspondence is not a confidential mode of communication.)

Phone:

Can we leave a message for you?

Best Place to Leave a Message (   )

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Referred by (if any):

Place / type of current employment:

How long?

If unemployed, how long:

What type of work did you do?

How did you decide to work with me at this time?

What are your top three challenges right now that need immediate attention?

What outcomes would you like to see at the end of our work together?

What are your top 2 strengths?

What do you feel most passionate about or inspired by?

What has been one of the biggest things you've had to overcome in your life?

Would you like to add anything you feel I should know about before our first meeting?

Anything specific you would like to learn about about your neurodivergent wiring?

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History

Have you worked with a mental health professional or coach in the past?

If yes, please describe your experience.

History of treatment

Date of any diagnosis (estimate)

List any medications you have taken in the past:

List any medications you are presently taking and dosage:

Past treatment effectiveness

Alternate therapies tried or currently using?

Current relationship status:

How would you rate your relationship (scale of 1-10 with 1 being poor and 10 being exceptional)

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

When was your last full physical exam?

Please list any current specific health problems:

Where do you rate your self-care right now (scale of 1 to 10, with 10 being the highest)

How would you rate your current physical health?

How would you rate your current sleeping habits?

Do you currently experience sleep issues? If yes, please describe:

How many hours of sleep do you get on average?

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How many times per week do you exercise?

What types of exercise / movement do prefer?

Please list your success(es) with good nutrition:

Any current challenges with food?

Do you spend time relaxing? If yes, how:

Are you currently experiencing overwhelming sadness, grief or depression?

If yes, for approximately how long?

Are you currently experiencing anxiety, panics attacks or have any phobias?

If yes, when did you first experience this?

Do you have chronic pain? If yes, please describe:

Are you currently taking any prescription medication? If yes, please list:

Have you ever been prescribed psychotropic medication (antidepressant, stimulant, etc.)

If yes, please list with approximate dates:

How often do you drink alcohol?

If yes, how many times per week?

How much alcohol do you drink? (Drinks per week)

How often do you engage in recreational drug use, including marijuana?

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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. father, grandmother, uncle, etc.)

Family History of…	**Which Family Member?**
Alcohol/Substance Abuse	
Anxiety	
Depression	
Domestic Violence	
Eating Disorders	
Obesity	
Obsessive Compulsive Behavior	
Schizophrenia	
Suicide / Suicide Attempts	
Bipolar 1 / Bipolar 2	
ADHD	
Spectrum Disorder	
OCD	
PTSD	
Other	

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Select everything that has happened to you in the past two years:

Death of a spouse/partner

Death of a family member

Major illness/injury of self

Major illness/injury of relative

Job dissatisfaction

Marriage Problems

Divorce

Family Issues (with children/parents/in-laws)

Financial issues

Legal Problems

Loss of job

Move to another city or state

Bad break up

Other (please specify)

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Select Anything That *Currently* Applies to You:

Headaches	Take Sedatives	Age
Shyness	Relationship(s)	Sexual Abuse
Anxiety	Sexual Problems	Unhappiness
No Appetite	Home Conditions	Self-Esteem
Insomnia	Motivation	Fainting Spells
Inferiority	Health Problems	Stress
Bowel Troubles	Future	Self Control
Suicidal	Weight	Making Decisions
Overeating	Fears	Energy
Temper	Dizziness	Loneliness
Parenthood	Relaxation	Allergies
My appearance	Legal Matters	Under eating
Career Choices	Memory	Concentration
Mood Swings	Separation	My Thoughts
Nervousness	Drug Use	Finances
Stomach Trouble	Use of Alcohol	Children
Fatigue	Work	Depression
Anger	Friends	Physical Abuse
Nightmares	Divorce	

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Consent for evaluation and treatment

Again, thank you for completing this form.

I hereby give consent for evaluation and treatment. It is agreed that either Don and/ or myself can discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

Name of client / please print:

Name of client / signature:

Date: