Dr. Marguerite Stagg, Psy.D, L.P.
GROWING EDGE THERAPY

# Individual Intake Questionnaire

Today's Date: _________________

**Note**: If you have been a client before, please fill in only the information that has changed.

## A. Identification

Name: _________________________ Date of Birth: ________________ Age: ______

Nicknames/Aliases: ___________________________ Email:

Home Address: _______________________________________________ Apt.: _____

City: ____________________________ State: __________ Zip: __________________

Home Phone: ___________________________ Cell Phone: _____________________

Calls will be discreet, but please indicate any restrictions: ________________________

## B. Referral: Who gave you my name to call? ___________________________

Name: __________________________________ Phone: _________________________

Address: ________________________________________________________________

May I have your permission to thank this person for the referral? Yes ☐ No ☐

How did this person explain how I might be of help to you? _______________________

## C. Chief Concern

Please describe the main difficulty that has brought you to see me: __________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Have you ever had any of the following problems?

| | | | | | |
|---|---|---|---|---|---|
| Head Injuries | Yes ☐ | No ☐ | High Blood Pressure | Yes ☐ | No ☐ |
| Stroke | Yes ☐ | No ☐ | Heart Disease | Yes ☐ | No ☐ |
| Cancer | Yes ☐ | No ☐ | Meningitis | Yes ☐ | No ☐ |
| Diabetes | Yes ☐ | No ☐ | Loss of Consciousness | Yes ☐ | No ☐ |
| Thyroid Disease | Yes ☐ | No ☐ | Headaches | Yes ☐ | No ☐ |
| Alcoholism | Yes ☐ | No ☐ | Drug Problems | Yes ☐ | No ☐ |
| Fainting/Dizziness | Yes ☐ | No ☐ | Depression | Yes ☐ | No ☐ |
| Convulsions | Yes ☐ | No ☐ | Anxiety | Yes ☐ | No ☐ |
| Memory Problems | Yes ☐ | No ☐ | Problems With Sex | Yes ☐ | No ☐ |
| Hallucinations | Yes ☐ | No ☐ | Extreme Tiredness | Yes ☐ | No ☐ |
| Crying Spells | Yes ☐ | No ☐ | Heart Palpitations | Yes ☐ | No ☐ |
| Appetite Changes | Yes ☐ | No ☐ | Suicidal Thoughts | Yes ☐ | No ☐ |
| Sleep Difficulties | Yes ☐ | No ☐ | Difficulty Concentrating | Yes ☐ | No ☐ |

## D. Treatment

1. Have you ever received psychological or psychiatric or counseling services before?

Yes ☐ No ☐ If yes, please indicate:

| WHEN? | FROM WHOM? | FOR WHAT? | RESULTS? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

2. Have you ever taken medications for psychiatric or emotional problems?

Yes ☐ No ☐ If yes, please indicate:

| WHEN? | FROM WHOM? | FOR WHAT? | RESULTS? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## E. Family History

Have any of your BLOOD RELATIVES ever had any of the following:

**WHO?**

Alcoholism Yes No ______________________ ______________________
Depression Yes No ______________________ ______________________
Mental Illness Yes No ______________________ ______________________
Epilepsy Yes No ______________________ ______________________

Neurological Disorder Yes No ______________________ ______________________
Suicide Attempts Yes No ______________________ ______________________
Hallucinations Yes No ______________________ ______________________
Drug Problems Yes No ______________________ ______________________
Psychiatric Treatment Yes No ______________________ ______________________

**F. Significant Relationships**

| | Your age when started | Person's age when started | How long | Reason for ending |
|---|---|---|---|---|
| Current | | | | |
| First | | | | |
| Second | | | | |
| Third | | | | |

**G. Current Living Situation**

1.Please describe your current living situation, including any family members or roommates living with you: ______________________________________________

______________________________________________________________

2.Children (and ages):

______________________________________________________________

______________________________________________________________

**H. Education/Employer**

Highest grade/degree completed? _____________ College/Graduate ________________

Major(s): ______________________________________________________

Employer: _____________________________________________________

Occupation: ___________________________________________________

Address: ______________________________________________________

Phone: ________________________________________________________

***This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law***