Dr. Christopher Barrilleaux, MATh, MSW, LCSW-BACS, DSW
Licensed Clinical Social Worker
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Intake Questionnaire

By answering this questionnaire completely and honestly you will assist me in gathering the information I need in order to help you. The information disclosed is considered *Confidential & Privileged* and will not be released to any other party without your express written consent.

NAME_____ SOC SEC #_____insurance/ only

ADDRESS_____ DAY PHONE_____

CITY/STATE_____ NIGHT PHONE_____

ZIP CODE_____ CELL / PAGER_____

BIRTHDATE_____ E-MAIL_____

TODAY'S DATE_____

Referral Information & Other Disclosures

REFERRED BY:_____

Whom do we contact in case of an emergency?_____

Your relationship to this person?_____ Phone_____

Who is responsible for your bill?_____

Your relationship to this person?_____

May we verify this information with the guarantor of your account? _____

Personal & Medical Information

Occupation:_____ Employer:_____

Educational Level: *Circle one of the following:*

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

Degrees earned or worked toward:_____

Do you have any children?_____

Name of Child	*Age*	*Parent's Names*

Are you currently in a partnered relationship? ____Yes ____No

If yes, what is the first name of your partner?_____

What are your hobbies?_____

Have you had prior treatment or counseling before? _____Yes _____No

Treatment Agency ***Name of Doctor /Therapist*** ***Reason for Treatment***

Are you presently on any medication? ____Yes ____No

If yes, please list:_____

_____

_____

Have you ever taken any psychiatric medications? ____Yes ____No

Who is your primary care physician?_____

When is the last time you had a physical examination?_____

How many times have you been hospitalized?_____ If yes, for what?_____

_____

Are you currently being treated for any illnesses? ____Yes ____No If yes, please list:

_____

_____

Do you have (had you had) any injuries? ____Yes ____No If yes, please list:

_____

_____

Do you currently see a psychiatrist? ____Yes ____No If yes, who?

_____

What is your main reason for being here today?

_____

_____

_____

_____

Clinical Information

Place a check (√) by all which apply. Put two checks (√√) for more serious problems and three checks (√√√) for the ones you consider really severe:

_____depression
_____alcohol abuse
_____nightmares
_____feeling down, blue
_____money problems
_____worried about my spouse
_____drug abuse
_____medical problems
_____thoughts of suicide
_____haunted by my past
_____anger
_____seeing things
_____highly irritated
_____chemical dependency
_____overeating
_____inability to concentrate
_____cravings
_____stuttering / stammering
_____sluggishness
_____feeling misunderstood
_____people are trying to frame me
_____problems at work
_____pregnancy
_____attention deficits
_____problems with intimacy
_____female problems
_____homicidal thoughts
_____unemployment
_____banking overdrafts
_____obesity
_____migraine headaches
_____respiratory problems
_____compulsive behaviors
_____germs and cleanliness
_____HIV
_____afraid of getting old
_____afraid I may be gay
_____partner's immaturity
_____bipolar disorder
_____keeping secrets
_____parenting

_____anxiety
_____marital problems
_____work or school performance
_____agitation
_____legal problems
_____mood swings
_____difficulty making friends
_____worried about my child
_____worried about the future
_____stress
_____demons
_____masturbation
_____panic attacks
_____gambling
_____anorexia or bulimia
_____short attention span
_____I'm told I have a temper
_____obsessive thoughts
_____deviant fantasies
_____problems relaxing
_____my partner is an addict
_____problems at school
_____sexual addiction
_____low frustration-tolerance
_____sexual dysfunction
_____violence
_____feeling unloved
_____arguments with the ones I love
_____vomiting
_____chronic pain
_____being overweight
_____manic-depression
_____urges to steal
_____sexually transmitted diseases
_____perfectionism
_____death of a loved one
_____living with a control freak
_____family problems
_____no one to talk to
_____people are out to get me
_____a loved one is terminally ill

Insurance

Insured's Name: _____

Insured's Birthdate:_____ Insured's Employer_____

Insurance:_____ Group #_____

Policy or Subscriber #:_____

Policyholder Birthdate:_____

Verification Phone_____

Address to submit claims: _____

Release of Information

I, _____, the undersigned, authorize the Provider to release confidential information limited to diagnostic impression and dates of services to the insurance carrier. Further records release will require new consent forms.

_____ _____

Patient Signature *Date*

Assignment of Benefits

I, _____, the undersigned, authorize benefits from my insurance plan to be paid directly to the Provider. I understand that in the event my insurance carrier pays a benefit check directly to me, the patient, that I am responsible for paying my provider directly.

_____ _____

Patient Signature *Date*