JESSICA ANNE DEEB, LCSW, LLC

CONFIDENTIAL INTAKE QUESTIONAIRE

Name:

Date: _____Name: _____(Maiden & Married)

Street: _____Apt/Bldg: _____

City: _____State: _____ Zip: _____

Cell Phone: _____OK to leave message? _____

Home Phone: _____OK to leave message? _____

Work Phone: _____ OK to leave a message? _____

E-mail: _____DOB: _____Age:_____

Social Security Number: _____ Race: _____

Driver's License Number: _____

PCP: _____Telephone Number:_____

Other Current Medical Professionals

(Psychiatrists, Psychologists, Counselors, Support Groups, etc.): Telephone Number:

_____ _____

_____ _____

_____ _____

Referral Source: _____

Reason for counseling/How long have you struggled with this:

_____

_____

_____

_____

_____ _____

Jessica Anne Deeb, LCSW Date

9400 River Crossing Blvd., Ste. 102, New Port Richey, 34655 • 105 S. Albany Ave., Tampa, 33606
Office 1-727-808-4818 • Fax 1-727- 375-8631 • www.jessicadeeb.com

JESSICA ANNE DEEB, LCSW, LLC

CONFIDENTIAL INTAKE QUESTIONAIRE

Name:

Emergency Contact (Name/Number): _____

Emergency Contact (Name/Number):_____

Highest Education: _____

Profession:_____

Employer/School:_____

Religion/Spirituality:_____

List names of your family members growing up (parents and siblings).

Name	Relationship	Age	Current Type of Relationship (close, not speaking, etc.)	City/State

Status: Single Relationship Cohabit Married Separated Divorced Widowed

How long?_____ Name of partner:_____ Age: _____

_____ _____

Jessica Anne Deeb, LCSW Date

JESSICA ANNE DEEB, LCSW, LLC

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Name:

Relationship History:

Names of Select Important Previous Partners	Length of Relationship	Why ended

Any discontinued pregnancies? _____ How many full term pregnancies? _____

List names of your children:

Names of Children	Biological, step, adopted, etc.

_____ _____

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Name:

Others living in your household (including pets):

Name	Relationship	Age	Current Type of Relationship (close, not speaking, etc.)	City/State

MEDICAL HISTORY

Allergies:

_____

List any serious illnesses with approximate dates:

_____

_____

List major surgical operations with approximate dates

_____

_____

Are you currently being treated for any physical illnesses?

_____

_____

_____ _____

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Name:

Describe any physical handicaps or physical ailments:

_____

_____

Current Medications:

Rx	Prescribed by	Date	Amount	Times taken per day	Outcome

QUESTIONS

What are some things you would like to be different in your life? Once written, number each starting from #1 - with #1 as most important to least important.

_____

_____

_____

_____

_____

_____

_____ _____

Jessica Anne Deeb, LCSW Date

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Name:

What are some things you do that get in the way of making positive changes?

_____

_____

_____

How many hours of sleep do you normally get? How many do you need?

_____

_____

How is your appetite?

_____

_____

Interests/Activities:

_____

_____

_____

Strengths:

_____

_____

_____

_____ _____

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JESSICA ANNE DEEB, LCSW, LLC

CONFIDENTIAL INTAKE QUESTIONAIRE

Name:

_____ _____

Jessica Anne Deeb, LCSW Date

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