CYNTHIA SHINABERRY, LCSW

1600 W. Eau Gallie Blvd, Suite 201-L Melbourne, FL 32936

Intake Questionnaire

Please provide the following information. This information is to be used by me your therapist and will become part of your confidential records.

Today's date: _____ Referred by: _____

Clients will first and last name: _____D.O.B. _____

Address: _____ City: _____

State: _____ Zip: _____Phone: _____ Work phone: _____

occupation: _____how long: _____Employer: _____

Military service (including dates):_____

Spouse: _____Phone number:_____

Household members/children

_____ _____ _____
Name age relationship

_____ _____ _____
Name age relationship

_____ _____ _____
Name age relationship

_____ _____ _____
Name age relationship

Nearest relative that (not living with you) _____ _____
Name Relationship

Address:_____

City: _____state:_____ zip:_____

Emergency contact:

Name: _____

Address: _____Phone: _____

City: _____state:_____ zip:_____

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Physician: _____ Phone:_____

Address: _____Last physical:_____

Why are you seeking treatment?

_____
_____
_____

When did the symptoms begin?

_____
_____

What do you think will help you?

_____
_____

Please describe any current or past physical problems you have:

_____
_____
_____
_____

Please describe any current or past physical problems your family members may have

_____
_____
_____

How significant is your religion\spirituality to you?

_____

Have you ever received counseling before?

When?

_____
_____

Where?

_____
_____

Reason:

_____
_____
_____
_____

P (410) 961-5917 **F** (321) 241-4687