



Practice Locations in Coeur d'Alene, ID and Williamsburg, VA
Phone: (757) 645-7722, Fax: (757) 645-2808
www.safeharborcounselingcenter.com

INTAKE QUESTIONNAIRE

Please provide the following information and complete the questions below as honestly and thoroughly as possible. This information serves to aid the therapist with gathering the appropriate information in the initial intake appointment and for navigating the therapeutic process. Please note that information you provide here is protected as confidential information and this document will remain in the client's record.

Client Name: _____ Date of Birth: _____ Date Completed: _____

1. What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can. _____

2. What are your goals for counseling? _____

3. Have you seen a mental health professional before? If so, please specify approximate dates, where you were seen, reason for counseling and your overall experience.

4. Specify all medications and supplements you are presently taking and for what reason.

5. If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

6. Who is your primary care physician? Please include type of MD, name and phone number.

7. Do you drink alcohol? If so, describe type, amount, frequency.

8. Do you use recreational drugs? If so, describe type, amount, frequency.

9. Have you had thoughts or urges to harm yourself? (past and present self-harm or suicidal thoughts). If so, please describe.

10. Have you ever attempted suicide? If so, please describe. _____

11. Have you had thoughts or urges to harm others? (past or present). If so, please describe.

12. Have you ever been hospitalized for a psychiatric issue? If so, please describe.

13. Is there a history of mental illness in your family? If so, please specify who, relation to you, and type of mental illness, including alcoholism or substance abuse.

14. If you are in a relationship, please describe the nature of the relationship and months or years together.

15. Describe your current living situation. Do you live alone, with others, with family, etc...

16. What is your level of education? Highest grade/degree and type of degree. How satisfied are you with your level of education? Any past or present school difficulties?

17. What is your current occupation? What do you do? How long have you been doing it?

18. Please check any of the following you have experienced in the past six months.

<input type="checkbox"/> Increased appetite	<input type="checkbox"/> Isolation from others	<input type="checkbox"/> Fear
<input type="checkbox"/> Decreased appetite	<input type="checkbox"/> Fatigue/low energy	<input type="checkbox"/> Hopelessness
<input type="checkbox"/> Trouble concentrating	<input type="checkbox"/> Low self-esteem	<input type="checkbox"/> Panic
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Anger outbursts
<input type="checkbox"/> Excessive sleep	<input type="checkbox"/> Tearful or crying spells	<input type="checkbox"/> Legal issues
<input type="checkbox"/> Low motivation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Physical aggression
<input type="checkbox"/> Self-harming behaviors	<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Manic episodes
<input type="checkbox"/> Conflict with family	<input type="checkbox"/> Conflict with friends	<input type="checkbox"/> Relational issues
<input type="checkbox"/> Bullying	<input type="checkbox"/> Impulsive Decisions	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Behavioral issues	<input type="checkbox"/> Increase in tobacco, alcohol, marijuana, or other substance use. Specify _____	
<input type="checkbox"/> Hallucinations - auditory or visual. Please elaborate _____		
<input type="checkbox"/> Death or loss of loved one. Please elaborate _____		
<input type="checkbox"/> Other. Describe: _____		

19. Please check any of the following medical issues that apply to you.

<input type="checkbox"/> Headache	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Gastritis or esophagitis
<input type="checkbox"/> Head injury	<input type="checkbox"/> Angina or chest pain	<input type="checkbox"/> Irritable bowel
<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Kidney-related issues	<input type="checkbox"/> Chronic fatigue

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|---|---------------------------------------|---|
| <input type="checkbox"/> Bone or joint problems | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Faintness | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Urinary tract problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Heart valve problems |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness & tingling |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid issues |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hormone-related problems |
| <input type="checkbox"/> Other. Describe: _____ | | |

20. Please describe any issues in childhood, including prenatal or birth complications, developmental delays, trauma, abuse/neglect, sexual assault, frequent moving, adoption/foster care, death of loved one, etc.

21. Cultural and spiritual/religious beliefs are important considerations for the therapeutic process. Please elaborate on any specific values or beliefs that are important to you.

22. What else would you like me to know? _____

**Practice Locations: 206 Ironwood Dr. #1012, Coeur d'Alene, ID 83814
1320 Richmond Rd. #1053, Williamsburg, VA 23185**