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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.

___ Increased appetite	___ Isolation from others	___ Fear
___ Decreased appetite	___ Fatigue/low energy	___ Hopelessness
___ Trouble concentrating	___ Low self-esteem	___ Panic
___ Difficulty sleeping	___ Depressed mood	___ Anger outbursts
___ Excessive sleep	___ Tearful or crying spells	___ Legal issues, if so specify
___ Low motivation	___ Anxiety	_____

___ Increase in tobacco, alcohol, marijuana, or other substance use. Specify. _____

___ Self-harming behaviors	___ Suicidal thoughts/gestures	___ Physical aggression
___ Conflict with family	___ Conflict with friends	___ Relational issues
___ Bullying	___ Impulsive Decisions	___ Hyperactivity
___ Behavioral issues	___ Manic episodes	

___ Hallucinations - auditory or visual. Please elaborate _____

___ Death or loss of loved one. Please elaborate _____

___ Other. Describe _____

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

___ Headache	___ High blood pressure	___ Gastritis or esophagitis
___ Hormone-related problems		___ Irritable bowel
___ Head injury	___ Angina or chest pain	___ Chronic pain
___ Loss of consciousness	___ Kidney-related issues	___ Heart attack
___ Bone or joint problems	___ Chronic fatigue	___ Seizures
___ Dizziness	___ Faintness	___ Heart valve problems
___ Urinary tract problems	___ Fibromyalgia	___ Numbness & tingling
___ Shortness of breath	___ Diabetes	___ Hepatitis
___ Asthma	___ Arthritis	___ Thyroid issues
___ HIV/AIDS	___ Cancer	___ Other. _____

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? _____

    _____