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Intake Questionnaire

Please fill out this intake form to the best of your ability. All material contained in this form will remain strictly confidential.

Name: _____
Name of parent/guardian (if under 18 years of age):
_____
Address: _____
Home Phone: (____)_____ Okay to leave messages? ___Y ___N
Cell/Other Phone: (____)_____ Okay to leave messages? ___Y ___N
Email: _____ Okay to Email? ___Y ___N
** Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____
Birth Date: _____/_____/_____ Age: _____ Gender: _____

Relationship/Marital Status:
__In Relationship
__Single
__Domestic Partnership
__Married
__Separated
__Divorced
__Widowed

Cultural and/or Ethnic Identification: _____
Spiritual and/or Religious Identification: _____
Please list any children with age(s): _____
_____
Others living in the home: _____

Emergency Contact: (name)_____(phone)_____
Education: _____
Occupation/Employment: _____
How many hours of work per week? _____
Satisfaction level with work/occupation/employment: _____
_____
_____

Present Concern(s)
Please describe the reason(s) for seeking counseling (include date the concern started):

_____
_____
_____

History

Past Counseling or Mental Health Services:
Psychological or psychiatric treatment of any kind before? ___Y ___N
What type of care was received? Outpatient _____ Inpatient _____
When was the treatment? _____
How long was the treatment? _____
Was there prescribed medication? ___Y ___N
If yes, what was prescribed (include dosages if known)? _____
_____

Are you currently taking any prescription medication? ___Y ___N
If so, what type (include dosages if known): _____
_____
Family history of psychological or psychiatric treatment: _____
_____

Symptoms:
Please check if any of the following symptoms/problems/complaints are affecting you:

___ Eating/Appetite concerns
___ Sleeping difficulties
___ Decreased energy/Fatigue
___ Stress
___ Muscle tension
___ Unable to relax
___ Depression
___ Feeling alone
___ Trouble with daily activities
___ Isolation
___ Sexual concerns
___ Loss of interest in activities
___ Change in social interests
___ Tearfulness
___ Hopelessness/Helplessness
___ Decreased attention span
___ Inattentive/Distractible
___ Memory concerns
___ Difficultly planning ahead
___ Opposition
___ Anger outbursts
___ Impulse control
___ Mood changes
___ Anxiousness/Nervousness
___ Worry/Fear
___ Stealing
___ Lying
___ Legal problems
___ Money and financial concerns
___ Housing difficulties
___ Panic attacks
___ Rapid heart rate
___ Dizziness
___ Fainting
___ Numbness or tingling
___ Phobia
___ Sweating
___ Trouble breathing
___ Flashbacks of traumatic event
___ Nightmares
___ Racing thoughts
___ Hearing voices
___ Seeing things
___ Illness or physical health problems

___ Being a caregiver
___ Spiritual or Religious concerns
___ Conflict with an important person
___ Separation from loved one
___ Grief and/or loss
___ Death of an important person
___ Suicidal ideation
___ Suicide attempt
___ Other concern(s) not listed_____
___ Self-harm
___ Homicidal ideation
___ Drug use/abuse
___ Alcohol use/abuse
___ Work/School concerns
___ Marital/Relationship concerns
___ Family concerns
___ Friendships concerns
_____
_____
_____

Physical and Medical:

___How would you rate your current physical heath?
___Poor
___Unsatisfactory
___Satisfactory
___Good
___Very Good

Please list any specific health problems you are currently experiencing?
_____
_____

Sleep

How many hours of sleep do you get a night on average? _____
Do you typically feel rested? ___Y ___N
Any concerns (i.e. falling and/or staying asleep)? _____
_____

Exercise

Do you exercise or get physical activity on a consistent basis? ___Y ___N
If so, how many hours a week? _____ Type of activity: _____
_____
Any concerns (i.e. injuries, inactivity, etc)? _____
_____

Medical

Major accidents, surgeries, medical problems, illnesses, and/or traumatic events (include date(s)): _____
_____
_____

Date of last physical exam: _____
Under current medical treatment: ___Y ___N If so, why: _____
_____
Current medications: _____
Over the counter medications:_____
Allergies: _____

Eating and Nutrition
How many meals do you eat a day on average? _____
Do you typically feel like you get enough nutrition? ___Y ___N
Any concerns (i.e. not getting enough or getting too many calories)? _____
_____

Substance Use
Caffeine: ___Y ___N Type: _____ # of drinks per day _____
Tobacco: ___Y ___N Type:_____ Use per day_____
Alcohol: ___Y ___N Type: _____ # of drinks per day _____ Week_____
Other drugs:___Y ___N Type: _____ Amount_____ How often_____

Describe the impact of substance use on your life: _____
_____
_____
Past treatment for substance use (if any): _____
_____
_____
Family history of substance use (if any): _____
_____
_____

Relationship:
Romantic
Are you currently in a romantic relationship?___Y ___N If yes, for how long? _____
How would you describe your relationship? _____
_____
Satisfaction level of relationship? _____
_____
Past significant romantic relationships and/or marriages: _____
_____-_____
_____

Sexual
Is your sex life satisfactory? ___Y ___N If not, what are your concerns _____
_____
In my opinion sex is _____
_____

Family Structure
Who do you currently live with and/or consider a part of your immediate family?
_____
How would you describe your family? _____
_____
_____

Friendships
How would describe your friendships and/or social life? _____
_____

Family of Origin

Siblings: ___Y ___N If so name(s) & age(s) _____

_____

How would you describe your family upbringing? _____

_____

Significant events (I.e. divorce, abuse, etc.): _____

_____

Current family or origin relationships (i.e. who are you close and in contact with?):

_____

_____

Personal Interests:

Please list some of your interests and/or hobbies: _____

_____

How is most of your free time occupied? _____

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Please list a few of your strengths: _____

_____

Please list a few areas that you find challenging or consider weaknesses:

_____

_____

What would you like to accomplish out of your time in counseling?_____

_____

_____

Motivation for counseling: _____

_____

Other Information that you would like to provide: _____

_____

_____

_____

_____

_____

Client/Legal Representative Signature Date

_____

Teresa Crossland, LPC Date