Intake Questionnaire

** indicates a required field*

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

*** What are your goals for counseling?**

Symptoms

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

- [ ] Increased appetite
- [ ] Decreased appetite
- [ ] Significant weight loss
- [ ] Significant weight gain
- [ ] Excessive sleep
- [ ] Decreased need for sleep
- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Nightmares
- [ ] Fatigue/low energy
- [ ] Depressed mood
- [ ] Low self-esteem
- [ ] Lack of or inability to feel emotions
- [ ] Isolation from others
- [ ] Low motivation
- [ ] Tearful or crying spells
- [ ] Grief
- [ ] Guilt/shame
- [ ] Worthlessness
- [ ] Hopelessness
- [ ] Suicidal thoughts
- [ ] Suicidal plan

- [ ] Suicidal attempts
- [ ] self-mutilation
- [ ] Anxiety
- [ ] Fear/worry
- [ ] Specific phobias
- [ ] Panic attacks
- [ ] Flashbacks
- [ ] Anger/hostility
- [ ] Irritability
- [ ] Aggressive behavior
- [ ] Violent temper
- [ ] Conduct problems
- [ ] Oppositional behavior
- [ ] Breaks things in anger (or hits walls)
- [ ] Stealing
- [ ] Dishonest/lies often
- [ ] Fire setting
- [ ] Gambling
- [ ] Promiscuous
- [ ] Lack of attachment
- [ ] Lack of empathy
- [ ] Frequent relationship distress
- [ ] Threatens self-harm
- [ ] Paranoia
- [ ] Elevated mood (mania)
- [ ] Mood swings
- [ ] Overly trusting of others
- [ ] Distrustful of others
- [ ] Delusions
- [ ] Dissociate states
- [ ] Trouble concentrating
- [ ] Hyperactivity
- [ ] Easily distracted
- [ ] Indecisive
- [ ] Immature
- [ ] Impulsive
- [ ] Binging/purging
- [ ] Obsessions or compulsions
- [ ] Sexual dysfunction
- [ ] Trauma victim/survivor (lifetime)
- [ ] Trauma perpetrator (lifetime)
- [ ] Hallucinations- Present
- [ ] Hallucinations- Not presently experiencing
- [ ] Other

*** Please check any of the following that apply**

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

*** Do you have any environmental, food or medication allergies? If yes, please list the allergen. If no, state NA**

BioPsychoSocioEconomic Assessment

* What strengths do you have which will aid in meeting your therapeutic goals? If you cannot think of any, please ask someone you trust like a spouse, friend, parent, teacher, etc.

* Please describe your current support system/level of support.

* Do you foresee any barriers which may get in the way of you reaching your therapeutic goals? If yes, please describe.

* Have you seen a mental health professional before?

- ○ Yes
- ○ No

List all medications and supplements you are presently taking including the reason for taking it, the dosage, the name of the prescribing doctor and their phone number and address. Please also include if you are compliant with each medication or supplement.

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

* Please describe your usual sleep, nutrition and exercise routine/patterns.

* Do you drink alcohol?

- Yes
- No

* Do you use recreational drugs (including marijuana)?

- Yes
- No

* Do you have suicidal thoughts?

- Yes
- No

* Have you ever attempted suicide?

- Yes
- No

* Do you have thoughts or urges to harm others?

- Yes
- No

* Have you ever been hospitalized for a psychiatric issue?

- Yes
- No

* Is there a history of mental illness in your family?

- Yes
- No

* Please describe your family of origin. Mother, father, step-parents, siblings, close family members. What was your relationship like with each of them? Were your parent's married, did they divorce/separate, was there violence or abuse in your childhood home, were you in foster care, did a parent pass away or was otherwise absent, etc.

* Please describe past significant relationships. If you are in a relationship, please describe the nature of the relationship and months or years together. Have your symptoms impacted your ability to have a healthy relationship? If yes, please describe.

* Describe your current living situation. Do you live alone, with others. With family, etc... Please list the names, ages of and the relationship to individuals you live with.

* What is your level of education? Highest grade/degree and type of degree. Did you have any problems in school? Have your symptoms impacted your ability to function in school? If yes, please describe.

*** Please describe your past work experience (not a resume)- Do you enjoy working, describe your work ethic, describe your work relationships, can you hold down a job, etc. If you have never had a job, please list this as well. What is your current occupation? What do you do? How long have you been doing it? Have your symptoms impacted your ability to function at work? If yes, please describe.**

*** Military History**

- [ ] Never in the military
- [ ] Served in the military- No incident
- [ ] Served in the military- with incident
- [ ] Current Reserves or National Guard
- [ ] Currently serving in the military
- [ ] Any information you feel necessary or relevant to state regarding military history

*** Please describe your spiritual, ethnic and cultural background.**

*** Please briefly describe any legal history.**

*** Please inform of any other agency involvement- Probation, Parole, Child and Family Services (CFS), Adult Protective Services (APS), etc.**

Developmental History

*** Problems during mother's pregnancy:**

- [ ] No problems
- [ ] High blood pressure
- [ ] Kidney infection
- [ ] German measles
- [ ] emotional stress
- [ ] bleeding
- [ ] alcohol use
- [ ] drug use
- [ ] cigarette use
- [ ] physical violence
- [ ] other

*** Birth**

- [ ] Normal delivery
- [ ] Scheduled cesarean- uncomplicated
- [ ] Emergency cesarean
- [ ] Difficult delivery
- [ ] Complications
- [ ] Preterm Delivery
- [ ] What was your birth weight?

*** Infancy**

- [ ] Feeding Problems
- [ ] Sleep problems
- [ ] Other
- [ ] No Problems

*** Childhood Health- Did you have any health concerns as a child. If yes, please describe. (Chicken pox, allergies, pneumonia, asthma, significant injuries, lead poisoning, tuberculosis, etc)**

* Delayed Developmental Milestones (check only those milestones that DID NOT occur at the expected age)

- [ ] Sitting
- [ ] Rolling over
- [ ] Standing
- [ ] Walking
- [ ] Controlling bowels
- [ ] Controlling bladder
- [ ] Sleeping alone
- [ ] Dressing self
- [ ] Engaging with peers
- [ ] Feeding self
- [ ] Speaking words
- [ ] Speaking sentences
- [ ] Tolerating separation
- [ ] Playing cooperatively
- [ ] Riding a tricycle or bike with training wheels
- [ ] Riding a bicycle w/o training wheels
- [ ] Other
- [ ] No delays in developmental milestones

* Childhood/ Adolescent Intellectual / Academic Functioning

- [ ] Normal intelligence
- [ ] High intelligence
- [ ] Learning problems
- [ ] Authority conflicts
- [ ] Attention problems
- [ ] Underachieving
- [ ] Mild retardation
- [ ] Moderate retardation
- [ ] Severe retardation
- [ ] Other

*** Childhood/ Adolescent Social Interactions**

- [ ] Normal social interaction
- [ ] Isolate self
- [ ] Very shy
- [ ] Alienate self
- [ ] Inappropriate sex play
- [ ] Dominate others
- [ ] Associate with acting out peers
- [ ] Promiscuity
- [ ] Other

Final Question

*** What else would you like me to know?**