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.