

## Intake Questionnaire

### Personal Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Type of email:  Work  Home  
 Ok to send me emails

Phone number: \_\_\_\_\_ Type of phone:  Work  Mobile  Home  
 Ok to leave voice message  Ok to send text message  
 Send me text message reminders for appointments

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Gender:  Female  Male  Transgender  Gender Queer  Other

Employment status:  Full-time  Part-time  Self-employed  Unemployed  
 Full-time student  Part-time student  Retired  Homemaker

Emergency Contact Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Type of Phone:  Work  Mobile  Home

### Demographics/Social History

What pronouns do you use (e.g., she/her/s)?

What is your racial and/or ethnic identity? Please list all that you see fit.

What is your sexual orientation?

What is your religious or spiritual background and/or affiliation?

To what extent does your religious or spiritual identity play an important role in your life?

Very important  Important  Neutral  Unimportant  Very unimportant

Do you have a disability? If so, please describe.

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

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

What is your level of education? Highest grade/degree and type of degree.

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

Are you currently involved in a lawsuit? If so, please describe.

### **Presenting Concerns**

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

How long have you struggled with the current issues for which you are seeking counseling?

What are your goals for counseling?

How ready are you to work on addressing the issues that brought you into counseling? Please check the one that applies to you.

- I do not think there is an issue
- I acknowledge that there is an issue but I feel ambivalent about change
- I acknowledge that there is an issue and I feel ready to take action
- I have taken actions to change and I am looking for ways to maintain my gains

**Referral Source**

How did you hear about me? Check all that applies:

- Google
- Psychology Today
- Primary Care Provider: Name \_\_\_\_\_
- Another Therapist: Name \_\_\_\_\_
- Friend or Family: Name \_\_\_\_\_
- Other  
 Please describe: \_\_\_\_\_

**Mental Health and Medical History**

Have you seen a mental health professional before? If so, provide the name(s) of your therapist, what you sought treatment for, how long the treatment lasted, and when the treatment ended.

If you have been in counseling before, what was helpful about your last therapist? What was not helpful?

List all medications and supplements you are taking presently, when you began taking them, dosage, and for what reason.

Name of Medication	Date Began Taking	Dosage	Condition Being Treated

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

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

Do you drink alcohol?  Yes  No If yes, describe type, amount, frequency:

Do you use recreational drugs?  Yes  No If yes, describe type, amount, frequency:

Do you have suicidal thoughts?  Yes  No If yes, please describe:

Have you ever attempted suicide?  Yes  No If yes, please describe:

Have you ever purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)?  Yes  No If yes, please describe:

Do you have thoughts or urges to harm others?  Yes  No If yes, please describe:

Have you experienced trauma?  Yes  No If yes, please check all that applies:

- Emotional abuse
- Physical abuse
- Sexual abuse
- Unwanted sexual experience(s)
- Significant loss(es)
- Life-threatening experience(s)
- Other

Please describe: \_\_\_\_\_

Have you ever been hospitalized for a psychiatric issue?  Yes  No If yes, Please describe, where, when and why:

Is there a history of mental illness in your family? If so, please provide details.

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Increased appetite          | <input type="checkbox"/> Low self-esteem          | <input type="checkbox"/> Restricting food           |
| <input type="checkbox"/> Decreased appetite          | <input type="checkbox"/> Depressed mood           | <input type="checkbox"/> Purging food               |
| <input type="checkbox"/> Trouble concentrating       | <input type="checkbox"/> Tearful or crying spells | <input type="checkbox"/> Spiritual concerns         |
| <input type="checkbox"/> Difficulty sleeping         | <input type="checkbox"/> General anxiety          | <input type="checkbox"/> Concerns about health      |
| <input type="checkbox"/> Excessive sleep             | <input type="checkbox"/> Fear                     | <input type="checkbox"/> Flashbacks                 |
| <input type="checkbox"/> Low motivation              | <input type="checkbox"/> Hopelessness             | <input type="checkbox"/> Nightmares                 |
| <input type="checkbox"/> Isolation from others       | <input type="checkbox"/> Panic                    | <input type="checkbox"/> Harassment                 |
| <input type="checkbox"/> Fatigue/low energy          | <input type="checkbox"/> Binge eating food        | <input type="checkbox"/> Poor impulse control       |
| <input type="checkbox"/> Paranoid thinking           | <input type="checkbox"/> Irritability             | <input type="checkbox"/> Memory problems            |
| <input type="checkbox"/> Problems in relationships   | <input type="checkbox"/> Poor judgment            | <input type="checkbox"/> Drug or alcohol concerns   |
| <input type="checkbox"/> Problems with addiction     | <input type="checkbox"/> Compulsive behavior      | <input type="checkbox"/> Physical or sexual assault |
| <input type="checkbox"/> Chronic pain and/or illness | <input type="checkbox"/> Frequent worry           | <input type="checkbox"/> Racing thoughts            |
| <input type="checkbox"/> Identity concerns           | <input type="checkbox"/> Guilt/shame              | <input type="checkbox"/> Mood swings                |
| <input type="checkbox"/> Family conflict             | <input type="checkbox"/> Body image concerns      | <input type="checkbox"/> Peer conflict              |
| <input type="checkbox"/> Work/school problems        | <input type="checkbox"/> Social anxiety           | <input type="checkbox"/> Cultural adjustment        |
| <input type="checkbox"/> Other                       | <input type="checkbox"/> Death of a loved one     | <input type="checkbox"/> Sexual problems            |

Please describe:

What else would you like me to know?