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INTAKE QUESTIONNAIRE

Date:_____

NAME:_____ **SSN:**_____

DOB:_____ **AGE:**_____

ADDRESS: _____

_____

PHONE: Home:_____ **Is it ok to leave a phone message?** ___No ___Yes

Cell : _____**is it ok to leave a phone message?** ___No ___Yes

EMAIL: _____

Is it ok to email you regarding appointment times? ___No ___Yes

Referred by: Self Family Friend Doctor Counselor Advisor Administrator

Name/or Other_____

May I contact the person who referred you and inform them that you scheduled an appointment with me?

___No ___Yes

Emergency Information:

Name: _____ **Relationship**_____

Address:_____

_____

Phone: Home:_____ **Cell:**_____

If you are uncomfortable answering any questions on this form, you may leave them blank.
At our initial appointment we can review your answers in greater depth, help clarify your goals, and determine together an appropriate course of action.

Please describe yourself as fully <u>as you feel comfortable</u>:

Gender:

____Male ____Female ____Transgender
____ MTF
____ FTM

Race / Ethnicity

____ African / African-American
____ Arab / Arab-American
____ Asian Pacific Islander / Asian American
____ Caucasian, European-American
____ Chicano(a), Latino(a), Hispanic
____ Mexican / Mexican-American
____ Native American or Alaskan Native
____ Southeast Asian / Southeast Asian American
____Persian
____Biracial / Bicultural _____
____ Multiracial / Multicultural_____
____Other_____

Relationship Status

____ Single ____Married or Partnered ____Separated ____Divorced ____Widowed ____Other

Sexual Orientation

____Bi-Sexual ____Gay or Lesbian ____Heterosexual ____Queer ____Questioning

Languages spoken: _____

Religious affiliation/spirituality: _____

Involvement: None Some /irregular Active

Do you identify as having a disability? No Yes (please specify)_____

Residence: ____Alone _____With Others (please specify name, age, relationship): _____

_____

<u>School Information:</u>

School Name: _____ **Major:**_____

Class: Freshman Sophomore Junior Senior 5th Year Graduate Transfer Student

School Status: Full time Part time Continuing Education

GPA (if applicable): Current? _____ Last Semester? _____

<u>Employment Information:</u>

Employer: _____ **Employment:** Full time Part time # of Hours/week _____

PRESENTING COMPLAINT:

Please check (or highlight or bold if completing on computer) all issues that currently concern you:

- ☐ Academic/Work Problems
- ☐ Addiction Problems
- ☐ Adjusting to School/Work
- ☐ Alcohol Use
- ☐ Anxiety
- ☐ Assertiveness / Empowerment
- ☐ Athletic Performance
- ☐ Attention Deficit Disorder
- ☐ Bipolar (Manic - Depression)
- ☐ Body Image
- ☐ Clarification of Own Values
- ☐ Coming-out Process
- ☐ Confidence
- ☐ Decision Making
- ☐ Decreasing Own Suicidal Thoughts
- ☐ Depression
- ☐ Difficulty Choosing a Career / Job
- ☐ Disordered Eating
- ☐ Eliminating/Reducing Unhealthy Behavior
- ☐ Ending an Important Relationship
- ☐ Financial concerns
- ☐ Grief
- ☐ Identity / Multi-cultural Concerns
- ☐ Injury Recovery/Rehab
- ☐ Interpersonal Problems
- ☐ Internet / Gaming Addiction
- ☐ Life Transition
- ☐ Obsessions / Compulsions
- ☐ Physical / Medical Concern
- ☐ Relationship Problems
- ☐ Self-Acceptance / Esteem
- ☐ Self-care (hygiene, taking time for self)
- ☐ Self-Understanding
- ☐ Sexual Health Issues
- ☐ Sexual Orientation
- ☐ Sleep Disturbances
- ☐ Stress Management
- ☐ Substance Use
- ☐ Working Through a Traumatic Event(s)

☐ Other (specify): _____

Please check (or highlight or bold if completing on computer) all the following symptoms that you have experienced:

☐ = Recent (within the last month) ○ = Past (one month ago or longer)

- ☐ ○ change in appetite
- ☐ ○ significant weight gain/loss
- ☐ ○ change in mood
- ☐ ○ irritability
- ☐ ○ feelings of worthlessness
- ☐ ○ changes in sleeping patterns
- ☐ ○ loss of energy
- ☐ ○ loss of interest in activities
- ☐ ○ loss or decrease in sexual interest
- ☐ ○ lost or irregular menstrual cycle
- ☐ ○ increase of energy
- ☐ ○ difficulty concentrating
- ☐ ○ nightmares
- ☐ ○ substance abuse (alcohol or drugs)
- ☐ ○ problems with attention, motivation, memory
- ☐ ○ recurrent and excessive anxiety or worry
- ☐ ○ feelings of restlessness
- ☐ ○ trembling or shaking
- ☐ ○ accelerated heart rate
- ☐ ○ shortness of breath
- ☐ ○ sweating
- ☐ ○ chest pain
- ☐ ○ feelings of choking
- ☐ ○ nausea
- ☐ ○ recurrent thoughts of death
- ☐ ○ recurrent thoughts of wanting to commit suicide
- ☐ ○ recurrent thoughts of harming others
- ☐ ○ cutting, punching or burning myself
- ☐ ○ seeing things that others do not
- ☐ ○ hearing voices that others do not
- ☐ ○ paranoid thoughts

HISTORY OF PRESENTING COMPLAINT:

What is bringing you in for therapy?

When did you start having a problem with this?

Have you ever sought counseling for this concern in the past? ___No ___Yes

If yes, when and for how long?

Have you ever sought counseling for any other concern in the past? ___No ___Yes

If yes, when and for how long?

For what concern?

Have you found counseling helpful in the past? ___No ___Yes

Have you ever been hospitalized for mental health treatment? ___No ___Yes

If yes, was it voluntary? ___No ___Yes

Have you ever been admitted to residential or intensive outpatient services? ___No ___Yes

Where?_____ For how long? _____

SUICIDAL/HOMICIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS

Have you ever had…	*Current (if yes, describe)*	*Past (if yes, describe)*
thoughts of hurting yourself?	N Y	N Y
thoughts of suicide?	N Y	N Y
a plan for suicide?	N Y	N Y
an attempted suicide?	N Y	N Y
thoughts of hurting someone else?	N Y	N Y
an incident of actually hurting someone else?	N Y	N Y

Has anyone in your family or any of your friends attempted suicide? ___No ___Yes

Has anyone in your family or any of your friends completed a suicide? ___No ___Yes

COPING STRATEGIES AND STRENGTHS:
How have you coped with your presenting concern so far?

What strengths do you bring to this problem which will assist you in overcoming it?

Describe your support systems (friends, family, spiritual or cultural groups, etc.): Are they nearby? ___No ___Yes

FAMILY HISTORY:

Are your parents married / separated / divorced / remarried? If divorced, how old were you at that time?

With whom did you live as a child?

Did you experience any major transitions or moves in your past?

Have you lost any direct family members? ___No ___Yes
Please list:

Do any family members (parents, sibling, grandparents, etc.) have a history of mental illness (depression, anxiety, etc.)?
___No ___Yes
Please list:

Is there a history of alcoholism / substance abuse in your extended family? ___No ___Yes
Please list:

TRAUMA HISTORY:

Have you ever been a victim of a crime? ___No ___Yes

Have you ever experienced physical trauma (e.g., car accidents, assault, abuse, head trauma)?

Have you ever experienced emotional trauma (e.g., victim of crime, abuse, loss or death of relative / friend)?

Have you ever experienced sexual trauma (e.g., sexual harassment, sexual assault) ?

LEGAL HISTORY: Have you ever been arrested or convicted of a legal violation? ___No ___Yes

MEDICAL HISTORY

Have you ever experienced a head injury? ___No ___Yes
Please describe:

Have you ever lost consciousness? ___No ___Yes
For how long?

Have you ever had any surgeries? __No ___Yes
Please describe:

Have you ever been hospitalized for a medical condition? __No ___Yes
Please describe:

Please list current medications and dosage:

_____ _____ _____ _____

_____ _____ _____ _____

From whom do you get your prescriptions for your psychotropic medications?

Clinic / doctor's name:_____ **Phone:** _____

Address:_____

SUBSTANCE USE HISTORY: Please indicate your use of the following substances:

List	Current Use Frequency # of days of the week	Current Use Amount Per Day	Past Use Frequency # of days of the week	Past Use Amount of Use Per Day
Alcohol _____	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Other	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

When was the last time you had more than 4 drinks on 1 occasion?

Have you ever experienced a black out from drinking too much alcohol? ___No ___Yes

If yes, how many? _____ Date of last black out_____

Have you ever tried to stop or reduce your alcohol / substance use? ___No ___Yes

Were you successful? ___No ___Yes

Do other people consider your alcohol / substance use a problem? ___No ___Yes

Is there anything else that you think is important for me as your therapist to know about? If yes, please describe:

How much reluctance do you have about coming in for therapy? Please circle one:

No reluctance at all *Very little* *Some reluctance* *Quite a bit* *Strong reluctance*

How motivated are you to make changes related to improving your presenting concern? Please circle one:

No motivation at all *Very little* *Some motivation* *Quite a bit* *Strong motivation*

PLEASE DESCRIBE YOUR GOALS FOR THERAPY: