INTAKE QUESTIONNAIRE

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?

Mental health history- Please tell me about any previous therapy experiences you have had.

Have you ever been hospitalized for mental health reasons and if so when?

Specify all medications and supplements you are presently taking and for what reason.

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. Also please list any chronic medical conditions, significant illnesses or injuries (including head injuries).

Who lives in your household with you? (Name, age, relationship to you)

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

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?

Do you drink alcohol/smoke cigarettes/use drugs? If yes, please specify what and how often.

Do you exercise, and if so, how often?

What are your eating habits? (Balanced, specific diet, poor nutrition, etc.)

Describe how well you sleep. (Difficulty falling asleep, staying asleep, wake up not feeling rested, hours of sleep)

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

Is there a history of mental illness in your family?

- ❍ Yes
- ❍ No

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

- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Trouble concentrating
- ❑ Lack of interest in pleasurable activities
- ❑ Indecisiveness
- ❑ Low motivation
- ❑ Isolation from others
- ❑ Fatigue/low energy
- ❑ Low self-esteem
- ❑ Loneliness
- ❑ Worthlessness
- ❑ Agitation
- ❑ Outbursts of anger
- ❑ Activities with the potential to harm self
- ❑ Often interrupting others
- ❑ Procrastination
- ❑ Easily distracted
- ❑ Impulsivity
- ❑ Inability to sit still
- ❑ Difficulty organizing
- ❑ Starts but doesn't finish task
- ❑ Bedwetting
- ❑ Fire setting
- ❑ Stealing
- ❑ Physical fights
- ❑ Depressed mood
- ❑ Tearful or crying spells
- ❑ Anxiety
- ❑ Fear
- ❑ Hopelessness
- ❑ Panic
- ❑ Excessive worrying
- ❑ Trembling
- ❑ Headaches
- ❑ Stomachaches
- ❑ Feeling like you're going crazy
- ❑ Racing thoughts
- ❑ Argumentative
- ❑ Destruction of property
- ❑ Nightmares
- ❑ Obsessive thoughts
- ❑ Withdrawal from friendships
- ❑ Decrease in socialization
- ❑ Hypervigilance
- ❑ Easily startled
- ❑ Memory problems
- ❑ Flashbacks
- ❑ Intrusive memories
- ❑ Numbness
- ❑ Feeling detached from oneself
- ❑ Compulsive behavior
- ❑ Inability to have loving feelings
- ❑ Other

Difficulty with Any of the Following:

- ❑ Caring for children
- ❑ Cleaning the house
- ❑ Cooking meals
- ❑ Driving the car
- ❑ Running errands
- ❑ Completing work/homework
- ❑ Functioning at work or school
- ❑ Eating properly
- ❑ Taking medications as prescribed
- ❑ Getting out of bed
- ❑ Exercising
- ❑ Other

What else would you like me to know?