STANDARD INTAKE QUESTIONNAIRE

What brings you to counseling at this time? Is there something specific--such as a particular event? Be as detailed as you would like to be.

How did you find me? Through a referral or in some other way? Do I have permission to thank them?

Have you seen a mental health professional before?

○ Yes
Please specify dates, reason for counseling, and type of experience. _____
_____
_____

○ No

If you have seen a counselor/therapist, what was the reason and when did you go? Are you currently seeing a counselor?

If you see a Psychiatrist, please list the name and phone number.

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

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

If any, what medications and/or supplements do you take? Please list the name, the dosage (mg/number of times per day), and purpose of the medication.

During the recent past, have you had any significant major illnesses, hospitalizations, or surgeries? If so, please elaborate.

Is your father/stepfather still living? If so, what is his current age and where does he live? If he is deceased, what was his age at death and the cause?

Is your mother/stepmother still living? If so, what is her current age and where does she live? If she is deceased, what was her age at death and the cause?

Do you have siblings? If so, please list in order their names, ages, and current place of residence. Also, where do you fall in the pack?

Is there a history of mental illness in your family?

- Yes Please describe _____
_____
- No

Have you ever been hospitalized for a psychiatric issue?

- Yes Please describe where, when, and why _____
_____
- No

Please check any of the following that apply

- Abandonment Issues
- Adoption
- Addiction to Something/Someone
- Alcoholism
- Anger
- Eating Disorder
- PTSD
- Suicidal Ideation
- Suicidal Attempt/s

Do you sleep well at night?

- Yes
- No Explain the reason _____

Do you exercise?

- Yes Describe type, amount, frequency _____
_____
- No

Do you drink alcohol?

- Yes Describe type, amount, and frequency _____
_____
- No

Do you use recreational drugs?

- Yes Describe type, amount, and frequency _____
_____
- No

Do you use tobacco products?

- Yes Describe type, amount, and frequency _____
_____
- No

During a 24-hour period, which indicates what your day is typically like?

- [ ] Under normal stress load
- [ ] Under considerable stress
- [ ] Resting or relaxed

What are your hobbies?

Describe your current living situation. Do you live alone, with another person, or with several other persons? Are any of them family members?

Please describe your current life status (single, cohabitating, engaged, married, separated, divorced, or widowed) and for how long you have been in that place.

If you have a spouse/significant-other, please state their name here along with their preferred name. Then list the name of their employer or work setting and their occupation.

If you have children/stepchildren, please list their full names, ages, genders, and residences.

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

If you are employed, by whom? Is your employment full-time, part-time, full-time student, part-time student, homemaker, or other?

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

Religious Affiliation/Preference

What are your goals for counseling?

What else would you like me to know?