Individual Intake Questionnaire

** indicates a required field*

*** How did you find me as your therapist (e.g., friend recommendation, doctor referral, Google search, provider directory search, etc.)?**

*** What is the reason you are coming in for counseling? Is there something specific, such as a particular event? When did this start or happen? How is your life affected by this issue? Please be as clear as you can be.**

*** What are your goals for our work together?**

*** Do you have, or have you ever had, a problem with self-harm (e.g., cutting, scratching, hair-pulling, etc.)?**

- ○ Yes
- ○ No

*** Do you have, or have you ever had, suicidal thoughts?**

- [ ] If yes, when?
- [ ] If yes, how would you end your life?
- [ ] No, I have never had suicidal thoughts.

*** Have you ever attempted suicide? Please list all attempts and your age when each happened, starting from the most recent event to the oldest event.**

- [ ] If yes, when?
- [ ] If yes, how did you do it?
- [ ] No, I have never attempted suicide.

*** Do you have, or have you ever had thoughts or urges to harm someone else or damage their property?**

- ( ) Yes
- ( ) No

*** Have you seen a mental health professional before? If so, please specify dates, the reason for counseling and your experience. What was your diagnosis, if any?**

- ( ) Yes
- ( ) No

*** Have you ever been hospitalized for a psychiatric issue? If yes, click and answer the corresponding questions. Otherwise, click no.**

- [ ] If yes, where?
- [ ] If yes, when did this happen?
- [ ] If yes, why?
- [ ] If yes, length of stay?
- [ ] If yes, diagnosis, if any?
- [ ] If yes, did the hospital help you?
- [ ] No, I have never been hospitalized for a psychiatric reason.

*** Who in your family/extended family has experienced:**

- [ ] Depression
- [ ] Anxiety
- [ ] Substance Abuse
- [ ] Suicide Attempt/died by suicide
- [ ] Other Psychiatric/Emotional Disturbance
- [ ] No one

*** Specify all psychotropic medications you are currently taking, for how long, and for what reason. What is the dosage of each? What time of day do you take it (morning, evening, bedtime)? Please include name and phone number of prescribing medical professional.**

*** Are you receiving care, to include medications, for any other medical conditions? Please include type of doctor, name, and phone number.**

Sleep and Rest

*** On a scale from 0 to 10 (0=very poor, 10=the very best), how would you rate your sleep?**

*** How many hours of sleep do you typically get?**

*** Do you feel rested upon waking?**

Diet and Eating Habits

*** Do you eat regular meals throughout the day?**

*** What do you find yourself typically eating?**

*** Do you think your meals are balanced?**

More About You

*** Do you exercise? If so, what do you do for exercise?**

*** How often do you exercise?**

*** How long is an exercise session, if any?**

*** How do you re-energize? Please list any activities, hobbies, spiritual interests that you enjoy or engage in as part of your self-care.**

*** Who do you know (not names) that you would consider your closest sources of support or your "inner circle" (e.g., grandparent, aunt, uncle, friend, cousin, etc.)?**

*** Describe your current living situation. Do you live alone, with others, with family, etc.? Is there a reason for your particular living situation?**

If you have children, please list their age, if they live with you and any other information you believe is important for me to know.

*** If you are in an intimate relationship, please describe the quality of the relationship and months or years together.**

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

*** What is your level of education? What is your highest grade/degree and type of degree?**

Concerns and symptoms

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

- [ ] change in appetite
- [ ] obsessive/compulsive behavior
- [ ] Trouble concentrating
- [ ] Difficulty sleeping
- [ ] Excessive sleep
- [ ] Low motivation
- [ ] Isolation from others
- [ ] Fatigue/low energy
- [ ] Low self-esteem
- [ ] Depressed mood
- [ ] Tearful or crying spells
- [ ] Anxiety
- [ ] Fear
- [ ] Hopelessness
- [ ] Panic
- [ ] Other

Have you ever experienced any of the following:

- [ ] Severe mood swings
- [ ] Problems with anger
- [ ] Extreme shyness or social anxiety
- [ ] ADHD/ADD
- [ ] Physical abuse
- [ ] Sexual abuse
- [ ] Emotional abuse
- [ ] Bullying
- [ ] Sexual assault
- [ ] Recent death or loss
- [ ] Other traumatic event
- [ ] Anorexia/Bulimia
- [ ] Disordered eating
- [ ] Alcohol abuse
- [ ] Marijuana abuse
- [ ] Other drug abuse
- [ ] Gambling problem
- [ ] Pornography abuse
- [ ] Excessive video/online gaming problem
- [ ] Legal problems
- [ ] Identity struggle/concern
- [ ] Health concern
- [ ] Sexual dysfunction
- [ ] Work related concern
- [ ] Religious or spiritual concern
- [ ] Cultural concerns
- [ ] Other

Please check any of the following that apply:

- [ ] Headache
- [ ] High blood pressure
- [ ] Gastritis, esophagitis, ulcer
- [ ] Hormone-related problems
- [ ] Head injury
- [ ] Angina or chest pain
- [ ] Irritable bowel
- [ ] Chronic pain
- [ ] Loss of consciousness
- [ ] Heart attack
- [ ] Seizures
- [ ] Chronic fatigue
- [ ] Dizziness
- [ ] Faintness
- [ ] Numbness & tingling
- [ ] Shortness of breath
- [ ] Diabetes
- [ ] Hepatitis
- [ ] Asthma
- [ ] Thyroid issues
- [ ] HIV/AIDS
- [ ] Cancer
- [ ] Other

* Who is your primary care doctor? Please include the type of doctor, name, and phone number.

*** Do you smoke cigarettes or use any nicotine products? If so, what and how often? Do you use them during sleeping hours?**

- ○ Yes
- ○ No, I don't use any nicotine products.

*** Do you currently drink alcohol or use marijuana? If so, describe the amount, and how often (daily, weekly, monthly, etc.).**

- ○ Yes
- ○ No

*** Do you currently use any other drugs? If so, describe type, amount, and frequency.**

- ○ Yes
- ○ No

*** Have you experienced any problems that are legal (e.g., police or court), medical (health-related), relationship (family, marriage, or partner), or employment (job-related) due to alcohol or drug use?**

- ○ Yes
- ○ No

*** What do you see as your top 5 strengths?**

What else would you like me to know?