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Intake Questionnaire

(Answer all questions as honest as you can but please feel free to leave any questions blank that you do not feel comfortable answering at this time).

1. **Do you have thoughts or urges to harm others?** ☐ Yes ☐ No
2. **Have you ever been hospitalized for a psychiatric issue?** ☐ Yes ☐ No
3. **Is there a history of mental illness in your family?** ☐ Yes ☐ No
4. **If you are in a relationship, please describe the nature of the relationship and months or years together.**

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

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

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

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

☐ Increased appetite
☐ Decreased appetite
☐ 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:________________________

9**. Please check any of the following that apply:**

- ☐ Headache
- ☐ High blood pressure
- ☐ Gastritis or esophagitis
- ☐ Hormone-related problems
- ☐ Head injury
- ☐ Angina or chest pain
- ☐ Irritable bowel
- ☐ Chronic pain
- ☐ Loss of consciousness
- ☐ Heart attack
- ☐ Bone or joint problems
- ☐ Seizures
- ☐ Kidney-related issues
- ☐ Chronic fatigue
- ☐ Dizziness
- ☐ Faintness
- ☐ Heart valve problems
- ☐ Urinary tract problems
- ☐ Fibromyalgia
- ☐ Numbness & tingling
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid issues
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Other:_______________

10**. What else would you like me to know?**

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

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12. **What are your goals for counseling?**

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13. **Have you seen a mental health professional before?** ☐ Yes ☐ No

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

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

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16**. Do you drink alcohol?** ☐ Yes ☐ No

17**. Do you use recreational drugs?** ☐ Yes ☐ No

18. **Do you have suicidal thoughts?** ☐ Yes ☐ No

19**. Have you ever attempted suicide?** ☐ Yes ☐ No