Standard Intake Questionnaire

Name:	Date:

1. What are the reasons you are coming to counseling at this time? Please be as detailed as possible and if there is a specific event please be as detailed as you feel comfortable.

2. What are your current symptoms and when did they start?

3. What contributing events in your life were occurring when the symptoms started?

4. Have the symptoms changed? If so, please describe how they have changed and when the changes occurred.

5. Please check any of the following that you have experienced in the last three months.
   - ☐ Trouble Concentrating
   - ☐ Increased appetite
   - ☐ Decreased appetite
   - ☐ Difficulty falling asleep
   - ☐ Excessive sleep
   - ☐ Difficulty sustaining sleep
   - ☐ Low motivation
   - ☐ Isolation
   - ☐ Low energy
   - ☐ Depressed mood
   - ☐ Crying spells
   - ☐ Anxiety
   - ☐ Hopelessness
   - ☐ Fear
   - ☐ Panic
   - ☐ Other, please describe:

6. Is there a current crisis or situation that needs a safety action plan?
   - ☐ No
   - ☐ Yes, please describe:

7. Are you aware of any triggers or situations that seem to bring up your symptoms or make them worse? If yes, please list any triggers you are aware of and what symptoms you experience.
   - ☐ No
   - ☐ Yes, please describe:

8. What are your goals you are hoping to achieve with counseling?

9. How would you know if counseling is successful? Describe what that would look like for you.

10. Have you been to counseling before?
☐ No ☐ Yes

11. If you have attended therapy previously, please provide the following information:
    a. Reason you attended?
    b. What memorable interactions you had if any?
    c. Length of treatment?
    d. What you found helpful or not helpful with therapy?
    e. What characteristics you find most helpful on a therapist?
    f. Reason for ending treatment?
    g. Results of therapy including any useful or disappointing aspects?
    h. Any areas that were never addressed that you feel is important now?

12. Please list current medications and supplements you are taking and for what reason. In addition, include your feelings on the effects of taking them.

13. If you are taking prescription medication, list your prescribing MD? Please include the type of MD, name and phone number.

14. Who is your primary care physician? Please include the name, address and phone number.

15. Please list any other medical history including past and/or present medical conditions.

16. Please provide the date of your last physical, lab work and concerns found if any.

17. Please check any of the following that apply:

☐ Headache	☐ High blood pressure
☐ Seizures	☐ Gastritis or esophagitis
☐ Head injury	☐ Hormone-related problems
☐ Chest pain	☐ Irritable bowel
☐ Faintness	☐ Bone or joint problems
☐ Chronic Pain	☐ Kidney-related problems
☐ Dizziness	☐ Heart valve problems
☐ Diabetes	☐ Urinary tract problems
☐ Hepatitis	☐ Numbness and tingling
☐ Asthma	☐ Shortness of breath
☐ Thyroid issues	☐ Fibromyalgia
☐ Cancer	☐ HIV/AIDS
☐ Thyroid issues	☐ Seasonal allergies
☐ Animal allergies	☐ Other, please describe:

18. Do you drink alcohol?

☐ No ☐ Yes, please describe the type, amount and frequency:

19. Do you use recreational drugs?

☐ No ☐ Yes, please describe the type, amount and frequency:

20. Do you have suicidal thoughts?

☐ No ☐ Yes, please describe the type and frequency:

21. Have you ever attempted suicide?

☒ No ☐ Yes, please identify the method and date it occurred:

22. Have you ever been hospitalized for a psychiatric issue?

☐ No ☐ Yes, please describe reason and dates.

23. Is there anyone in your family with a history of mental illness or brain health issues?

☐ No ☐ Yes, please describe.

24. Is there a history of alcohol or drug use in your family? ☐ No ☐ Yes, please describe.
25. Please list your current present significant relationships including spouse/partner/significant other/children with the supportiveness and length of the relationship.
26. Please list any other supportive people currently in your life. (friends/relatives/mentor/etc.)
27. Who would be supportive of you achieving your goals?
28. Would anyone in your life have an issue with your achieving your goals?
29. Can you think of any downside to you achieving your goals if therapy is successful? ☐ No ☐ Yes, please describe.
30. Describe your current living situation (alone, with others, with family, temporary housing, etc.).
31. Have you experienced any attachment issues in your childhood? ☐ No ☐ Yes, please describe.
32. Please describe your knowledge of your birth history (planned pregnancy or surprise, prenatal care, complications with delivery, full term or premature delivery, etc.).
33. Describe your relationship with your parents in childhood and currently.
34. Describe your parent's relationship with each other in childhood and currently.
35. Do you know if your parents or extended family have experienced trauma? ☐ No ☐ Yes, please describe.

36. Please include any other family members you grew up with, age and how they related to you.

37. Have you had any negative experiences related to race, ethnicity, culture, or nationality?
☐ No ☐ Yes, please describe.

38. Have you had any negative experiences related to gender identity or sexual preference?
☐ No ☐ Yes, please describe.

39. Have you had any negative experiences related to religious preference?
☐ No ☐ Yes, please describe.

40. Please describe any positive or negative school experiences with teachers/peers/activities/academic stressors.

41. Have you experience loss of significant people in your life?
☐ No ☐ Yes, please describe.

42. Have you ever been arrested, incarcerated or had a negative experience with police?
☒ No ☐ Yes, please describe.

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

44. What is your current occupation and how long have you been doing it?

45. Please list current hobbies and fun activities you enjoy.

46. What do you currently do to help calm yourself down or improve your mood when needed?

47. What do you identify as your strengths?

48. How do you best learn new information? (homework, watching videos, talking/auditory or a combination, etc.)
49. What else do you feel is important for me to know? 50.