Individual Intake Questionnaire

** indicates a required field*

Client Information

*** Therapist name who will be working with you?**

*** 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 detailed as you can.**

*** 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

*** Is there a history of mental illness in your family?**

- ○ 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.

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?**

*** Do you sleep continuously or do you toss and turn?**

How often do you wake up in your sleep (if applicable)?

If you wake up in your sleep, how long before you fall back asleep?

Diet and Eating Habits

* What do you find yourself typically eating?

* Do you eat regular meals throughout the day?

* 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?

* What do you like to do for fun or enjoyment? Do you have any hobbies that you enjoy regularly? Do you prefer your enjoyment alone, with others, or both?

* 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 are in a relationship, please describe the nature 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?**

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

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
- [ ] 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

*** 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)? Does it help?**

*** 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

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

*** 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? If so, describe the type, amount, and how often (daily, weekly, monthly, etc.).**

- Yes
- No

*** Do you currently use recreational 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 else would you like me to know?