Intake For Individual Counseling

This questionnaire will help me best understand your current difficulties as well as your past history. Please fill out this questionnaire to the best of your ability before your intake appointment and bring it with you. Read the questions carefully and answer them as fully as possible (use the reverse side of the paper if necessary). If there are questions that you don't understand, please mark them with a star (*) and we will review them with you at the intake appointment.

Personal Information

Date:

Name Date of Birth: Age:

Spouse / Partner Date of Birth: Age: Years together___

Children	Name(s)		Parents: Self	Partner	Ages:
1		Age			
2		Age	Siblings: Self	Partner	Ages:
3		Age			

Home address: Zip code

Telephone # H) (W) (C)

Telephone # Partner H) (W) (C)

Email

Email Partner

Education & Work History Self /Partner

Degrees/Diplomas /

Current Employment /

Past Employment /

Any diagnosed learning difficulties? If so in what subjects?

Any Attention Deficit Disorder (with or without Hyperactivity?)

Please list any significant medical history for you, your spouse, or your family.

Social/Behavioral/Health problems?

Spiritual Upbringing Y / N
If Yes, Past denomination A_____B_____

Current Spiritual Practice? Y / N If Yes, A _____

The following table is designed to assess your and your partner's ability to relate to others.

Check all that apply

- Difficulty relating to others?
- Verbally argue a lot with others?
- Difficulty making friends?
- Difficulty maintaining friendships?
- Have at least one good friend?
- Invited over to friend's houses?
- Have a small group of good friends?
- Prefer to be alone?
- Have difficulty with the non-verbal rules of social interaction (e.g. turn taking, how close to stand to others)

Y/N Do you like your partner's friends?
Add any comments about your social circumstances that are relevant:

What time do you go bed? What time do you get up? _

Is your sleep consistent? Y N

Concerned that you don't get enough sleep? Y N

Do you suffer from poor sleep quality? Y N

Alcohol use (Please circle)

Self	Never	Occasionally (1x/week or less)	2-4x/week	Daily
Partner	Never	Occasionally (1x/week or less)	2-4x/week	Daily

Drug use

Self	Never	Occasionally (1x/week or less)	2-4x/week	Daily
Partner	Never	Occasionally (1x/week or less)	2-4x/week	Daily

Drugs you have tried:

Do you use pornography? Y N Partner use pornography? Y N or Not Applicable ____

Other addictions or over-use or obsessive/compulsive problems: (ie gaming, gambling) Y N

If Yes, Please list:

Please describe any major family stressors that may have impacted you in the past or that may impact you now:

Are there any particularly traumatic or troubling events which have happened in your life which I should know about in order to understand you better? (please give details, include incidents you feel were traumatic even though they might not have been for someone else)

Have you ever witnessed violence inside or outside of the home? Y N

Has your partner ever witnessed violence inside or outside of the home? Y N

Have you ever had psychological counseling or therapy? Y N

If Yes, please give details below:

Psychiatric Diagnosis (Past and Present) Current Medications

Partner's Psychiatric Diagnoses (Past and Present) Current Medications

Therapist names, addresses, and telephone numbers of any other professionals consulted.
(This does not give me permission to contact them, and they will only be contacted with your written consent.)

What problems or questions have caused you to seek help at this time?

What changes do you hope will result from seeking psychological services?

Is there any additional information or anything that you feel is pertinent to know that has not been covered in this questionnaire?

Who referred you to Anchor Counseling Services Spokane? May I thank them?