Standard Intake Questionnaire Template

Do you have thoughts or urges to harm others?

- ○ Yes
- ○ No

What else would you like me to know?

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

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

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

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

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

If you are in a relationship, please describe the nature of the relationship and months or years together.

Is there a history of mental illness in your family?

- Yes
- No

Have you ever been hospitalized for a psychiatric issue?

- Yes
- No

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

Have you ever attempted suicide?

- Yes
- No

Do you have suicidal thoughts?

- ○ Yes
- ○ No

Do you use recreational drugs?

- ○ Yes
- ○ No

Do you drink alcohol?

- ○ Yes
- ○ No

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

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

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

Have you seen a mental health professional before?

- ( ) Yes
- ( ) No

What are your goals for counseling?