Intake Questionnaire
Your Song Counseling, PLLC

Today's date:_____________

General Information

Name:________________________________

Name that you go by:____________________________

Home Number:__________________ Work Number:___________________

Cell Number:__________________
Is it OK to leave detailed messages in your phone(s): ☐ Yes ☐ No

Address, City, State, Zip:____

Who are you living with:__________________________

Email Address:__________________________________

Date of Birth:_______________

Racial/Ethnic Identity:____

Gender Identity: ______________________________________

Your Pronoun: ☐ She/her ☐ He/him ☐ They/them

☐ Other (please explain):_______________________________

Sex Assigned at Birth (check one): ☐ Male ☐ Female ☐ Intersex

☐ Prefer not to answer

Sexual Orientation (check all that apply): ☐ Heterosexual ☐ Gay ☐ Lesbian

☐ Bisexual ☐ Asexual ☐ Fluid ☐ Polysexual ☐ Pansexual ☐ Questioning

☐ Other (please explain):________________________

Emergency Contact (this person may be contacted if clinician is concerned about your safety)
Emergency Contact Person's Name:_________________________________

Relationship:______________ Phone Number:________________________

Employment/School/Disability Information

Are you (please check all that apply) : ☐ Employed ☐ Home making

☐ Attending school ☐ Unemployed ☐ Disabled ☐ Retired

If employed, describe your occupation(s):___________________________

If attending school, what is your major(s):___________________________

Relationship Information

Current Relationship Status (check all that apply) : ☐ Single ☐ Married (1st, 2nd, 3rd)

☐ Divorced (1st, 2nd, 3rd) ☐ Widowed ☐ In a committed relationship ☐ In a

domestic partnership, living together ☐ Partnered, not living together

☐ Monogamous ☐ Polyamorous

If married/partnered/committed, spouse(s)/partner(s)/committed person/people's

name(s):____________________________

Number(s) of year(s) together:_____________________________

If divorced, what year(s) did you divorce:_____________________________

First name(s) and age(s) of your child(ren) (indicate if step, adopted or foster children) if any:

____

First name(s) and age(s) of your grandchild(ren) if any:

____

First name(s) and age(s) of your great-grandchild(ren) if any:

____

Medical History

Primary Care Doctor's Name:_______________________________

Phone Number:_____________________

Address:____

Current Medical Diagnosis:_______________________________________

Current Medication Names and Dosages:______________________________

Last Time Seen By Primary Care Doctor:_____________________

Current Non-Prescription Medication Use:______________________________

Frequency of Use:_________________

Alternative Treatment (e.g. naturopath, acupuncture):_________________________

Mental Health History (you will be requested to complete brief depression and anxiety tests)

Briefly describe why are you seeking treatment:__________________________

____

What would you like to change/accomplish with treatment:___________________

____

Have you been diagnosed with mental illness: ☐ Yes ☐ No

If yes, name of the diagnosis and year(s) when you were diagnosed (e.g. depression in 1975):____

Have you experienced any traumatic event (e.g. violence, abuse, crime, natural disaster, medical problems, losses, homelessness): ☐ Yes ☐ No

(If yes, you will be asked to complete a trauma test to examine how you are still impacted)

Have you received mental health treatment (e.g. counseling, psychiatric medication management): ☐ Yes ☐ No

If yes, which setting: ☐ Inpatient ☐ Outpatient ☐ Both ☐Other(describe):_________

Place(s), year(s) and length of treatment:_______________________________

____

Has your family member had mental health problems (e.g. depression, anxiety, bipolar, schizophrenia) : ☐ Yes ☐ No

If yes, describe (e.g. brother - depression):___________________________________

Substance Abuse History

Have you used any substances (e.g. alcohol, marijuana, methamphetamine, heroine, unprescribed medications such as Xanax, Opioid) **in the past year**: ☐ Yes ☐ No

If yes, the last time of use:______________________

Substance(s) of Choice:____

Amount:____________________________________

Frequency of Use (e.g. daily, weekly, monthly):_________________________

Are you receiving or seeking treatment for substance use: ☐ Yes ☐ No

If yes for receiving treatment, when did you start:____________________

Name(s) of Treatment Facility(ies):____________________________________

Do you currently smoke: ☐ Yes ☐ No
If yes, how much per day:________________

Do you currently take caffeine (e.g. coffee, tea, soda, chocolate): ☐ Yes ☐ No

If yes, what is it:______________________

How much per day:___________________

Have you used any substances **prior a year ago**: ☐ Yes ☐ No

If yes, what year(s):__________________________

Substance(s) of Choice:____

Have you received any treatment for substance use: ☐ Yes ☐ No

If yes, which setting: ☐ Inpatient ☐ Outpatient ☐ Both ☐ Other (describe):_________

Place(s), year(s) and length of treatment:________________________________

Has any of your family member had problems with substances: ☐ Yes ☐ No

If yes, describe (e.g. mother –alcohol):_______________________________________

Risk Issues
Have you thought of suicide: ☐ Yes ☐ No

If yes, when was it:_______________________________

Have you come up with any plan for suicide: ☐ Yes ☐ No

If yes, describe (e.g. overdose):____

Have you attempted suicide: ☐ Yes ☐ No

If yes, describe (e.g. overdose in 2008):_________________________________

Has any of your family member died by suicide: ☐ Yes ☐ No

If yes, describe (e.g. uncle in 2000):_____________________________________

Have you thought of homicide: ☐ Yes ☐ No

If yes, describe (e.g. neighbor, yesterday):_______________________________

Have you come up with any plan for homicide: ☐ Yes ☐ No

If yes, describe (e.g. run over math teacher):______________________________

Have you attempted homicide: ☐ Yes ☐ No

If yes, describe (e.g. boyfriend, poison, in 1980):___________________________

Has any of your family completed homicide: ☐ Yes ☐ No

If yes, describe (e.g. aunt, shot spouse, in 1999):_________________________________

Have you involved yourself into risky behavior (e.g. assault, arson, property damage, unsafe sex work, drug dealing): ☐ Yes ☐ No

If yes, describe (e.g. arson in 1974):______________________

Have you been involved into any legal system: ☐ Yes ☐ No

If yes, describe (e.g. assault 3 in 2003):___________________

Are you currently on probation: ☐ Yes ☐ No

Are you required to receive counseling by the court: ☐ Yes ☐ No
(I do NOT offer court-ordered counseling as mentioned on my counselor disclosure)