**Salazar Serenity Counseling**

**salazarserenitycounseling@gmail.com**

**361-236-7576**

**INTAKE QUESTIONARE**

**Name DOB Date**

**Email Phone**

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

What are your goals for counseling?

Have you seen a mental health professional before?

Yes

No

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

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

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

Do you drink alcohol?

Yes

No

Do you use recreational drugs?

Yes

No

Do you have suicidal thoughts?

Yes

No

Have you ever attempted suicide?

Yes

No

Do you have thoughts or urges to harm others?

Yes

No

Have you ever been hospitalized for a psychiatric issue?

Yes

No

Is there a history of mental illness in your family?

Yes

No

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

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

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

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

Please check any of the following you have experienced in the past six months

Increased appetite Panic

Decreased appetite Hopelessness

Trouble concentrating Fear

Difficulty sleeping Tearful or crying spells

Excessive sleep Depressed mood

Low motivation Low self-esteem

Isolation from others Fatigue/low energy

Other

Please check any of the following that apply

Headache Fibromyalgia

High blood pressure Numbness & tingling

Gastritis or esophagitis Shortness of breath

Hormone-related problems Diabetes

Head injury Hepatitis

Angina or chest pain Asthma

Irritable bowel Urinary tract problems

Chronic pain Thyroid issues

Loss of consciousness HIV/AIDS

Heart attack Cancer

Bone or joint problems Arthritis

Seizures Heart valve problems

Kidney-related issues Faintness

Chronic fatigue Dizziness

Other

What else would you like me to know?