Mending Mind Wellness Intake Questionnaire

Client: _____ DOB:_____ Date: _____
Start/End time_____ Initial
Diagnosis:_____ Present in session: Client Mother
Father Other(s): _____
Location: Manchester_____ Tilton_____ Concord_____ Telehealth_____

Reason for counseling and why now:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Client's Stated Goals:

_____
_____
_____
_____
_____

Current and ongoing symptoms: (scale is 0-10, 10 worse)

Nightmares	Restless	Feels numb
Flashbacks	Racing thoughts	Labile
Low energy	Panic attacks	Shame
Hopelessness	Anxiety (0-10) _____	Poor concentration
Tearful	Not eating	Low self esteem
Self-harm	Overeating	Worrying
Depression (0-10)_____	Headaches	Disassociation
Anger	Insomnia	Other:_____
Irritable	Conduct issues	_____
Outbursts	Hypervigilance	_____

What age did the symptoms start:

_____
_____

When were symptoms the worst and what were the life events surrounding that time?

_____
_____

Clinician Initials: _____

Social and Family: Present relationships and living situation-- spouse/partners/significant others/children (include the quality of these relationships):

Relationships with parents past and present - parents married/divorced, alive/passed away:

Siblings (include quality of these relationships) :

What was it like growing up in your house (abuse, neglect, domestic violence, substance abuse?):

Did you feel loved as a child?:

Have you ever been sexually abused?

Educational history (how did the client do academically/behaviorally, any school changes, any bullying in school?)

Medical History (any major medical diagnosis/surgeries or chronic illnesses?):

Current Medications:

Psychiatric history (past counseling and outcomes):

Previous diagnoses:

Family psychiatric history (maternal side):

Family psychiatric history (paternal side):

_____
_____
_____
_____
_____
_____

PRESENT	Ideations /	Behaviors	Plan?		Intent?	
Suicidal Ideation	yes	no	yes	no	yes	no
Homicidal Ideation	yes	no	yes	no	yes	no
Self Harm	yes	no	yes	no	yes	no

Description of Plan & Intent if applicable: _____
_____
_____
_____
_____

PAST	Ideations /	Behaviors	Plan?		Intent?	
Suicidal	yes	no	yes	no	yes	no
Homicidal Ideation	yes	no	yes	no	yes	no
Self Harm	yes	no	yes	no	yes	no

Description of Past Plan & Intent OR **ATTEMPT** history if applicable:

_____
_____
_____
_____
_____
_____
_____
_____

Employment History:

Religion/Spirituality:

Natural Support System:

Hobbies/activities:

Strengths:

Substance Abuse History:

	Caffeine	Tobacco	Alcohol	Rx Drugs	Non Rx
Current					
Past					

Clinician Initials:_____

Description of Substance Use history:

Client reported- most traumatic event:

Additional information:

Clinician Signature _____ Date _____