# Home Circle Counseling, LLC

## Intake Questionnaire For New Patients (Children & Adolescents)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

**Date**: _____ **Social Security Number**: _____

**Name**: _____ **Date of Birth**: _____ **Age**: _____

**Home Address**: _____ **City/State/Zip code**: _____

**Home Phone**: _____ **Cellular/Alternate Phone**: _____

**WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):**

| # | Name | Relation | Sex | Age | # | Name | Relation | Sex | Age |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | 4 | | | | |
| 2 | | | | | 5 | | | | |
| 3 | | | | | 6 | | | | |

**In your own words, describe the current problems as you see them:**

_____
_____
_____
_____
_____

**How long has this been going on?** _____

**What made you come in at this time?** _____
_____
_____

**What do you hope to gain from this evaluation and/or counseling?**

_____
_____
_____

**If you had difficulties in the past, what have you done to cope? Was it helpful?**

_____
_____
_____

**Symptoms**

Please **check** any symptoms or experiences that you have had **in the last month (30 days)**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed Mood
- ☐ Feeling Numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight? _____
- ☐ Weight gain: _____ lbs
- ☐ Weight loss: _____ lbs.

- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts
- ☐ Intrusive memories

- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memory
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else

- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Feeling puzzled as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses, or images
- ☐ Unusual visual experiences such as flashes of light, shadows
- ☐ Hear voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or the radio is communicating with you

- ☐ Difficulty problem solving
- ☐ Dependency on others
- ☐ Inappropriate expression of anger
- ☐ Difficulty or inability to say "no" to others
- ☐ Sense of lack of control
- ☐ Abusive relationship
- ☐ Concerns about your sexuality
- ☐ Difficulty meeting role expectations
- ☐ Manipulation of others to fulfill your own desires
- ☐ Self-mutilation/cutting
- ☐ Ineffective communication
- ☐ Decreased ability to handle stress
- ☐ Difficulty expression emotions

**Sexual Orientation:** ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ _____
☐ Transgender ☐ I choose not to answer

**Please describe any other symptoms or experiences you have had problems with:**

**Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?**
☐ No ☐ Yes If so:

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

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Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

| **Medication** | **Dosage** | **How long have you been taking it?** | **Has it been helpful?** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

| **Medication** | **Dosage** | **How long have you been taking it?** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you been on **PSYCHIATRIC** medication in the past? ☐ No ☐ Yes If YES, please list:

| **Medication** | **Dosage** | **First/Last time you took it** | **Effect of Medication** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If YES, describe:

| **Hospital** | **Dates** | **Reason** |
|---|---|---|
| | | |
| | | |
| | | |

**Have you ever attempted suicide?** ☐ No ☐ Yes If YES, describe:

_____

_____

_____

_____

## MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ Yes If YES, describe:

_____

_____

_____

_____

Current Weight: _____ **Family's Normal Diet:** Fast Food Home Cooked

Current Height: _____ Carbonated Drinks Plant-based Animal Product

**List any PRIOR illnesses, operations and accidents**

_____

_____

_____

## FAMILY HISTORY

***Father:*** Age: ☐ Living ☐ Deceased Cause of death:

If deceased, HIS age at time of his death____ YOUR age at time of his death_____

Occupation: _____ Health: _____

Frequency of contact with him: _____ Are you/Have you been close to him? _____

***Mother:*** Age: ☐ Living ☐ Deceased Cause of death:

If deceased, HER age at time of his death___ YOUR age at time of his death_____

Occupation: _____ Health: _____

Frequency of contact with him: _____ Are you/Have you been close to her? _____

***Brothers and Sisters***

| Name | Sex | Age | Whereabouts | Are you close to him/her? | |
|---|---|---|---|---|---|
| | | | | **No** | **Yes** |
| | | | | **No** | **Yes** |
| | | | | **No** | **Yes** |
| | | | | **No** | **Yes** |

**During your childhood, have you lived any significant period of time with anyone other than your natural parents?**

☐ No ☐ Yes If so, please give the person's name and relationship to you

Name: _____ Relationship to you:_____

**Please place a check mark in the appropriate box if these are or have been present in your relatives**

| | Brothers | Sisters | Father | Mother | Uncle/Aunt | Grandparents |
|---|---|---|---|---|---|---|
| **Nervous Problems** | | | | | | |
| **Depression** | | | | | | |
| **Hyperactivity** | | | | | | |
| **Counseling** | | | | | | |
| **Psychiatric Medication** | | | | | | |
| **Psychiatric Hospitalization** | | | | | | |
| **Suicide Attempt** | | | | | | |
| **Death by Suicide** | | | | | | |
| **Drinking Problem** | | | | | | |

## SOCIAL HISTORY

***Education***

Highest grade level completed so far: _____
Have you had any disciplinary problems in school? _____
If yes, please explain: _____
Were you considered hyperactive/ADHD in school? _____
If yes, were/are you on any medication? _____
If yes, were/are you on any medication? _____
If so, which medication? _____
What kinds of grades do you get in school? _____

Have you been arrested or had any contact with the police? _____
If yes, please describe: _____

Do you have a religious affiliation? _____
If yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Have you ever been abused?
☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____
_____

**SUBSTANCE ABUSE**

***Alcohol***
Do you drink alcohol? _____ If yes, age of first use _____
How much do you drink? _____
How often do you drink? _____
Do you use tobacco (cigarettes, dip)? _____
If yes, how often? _____

***Other Drugs:***
Please indicate for each drug listed below

| Drug | Ever Used? | Age at 1st use | Time Since Last Use | Approx use in last 30 days |
|---|---|---|---|---|
| Marijuana | | | | |
| Cocaine | | | | |
| Crack | | | | |
| Heroin | | | | |
| Methamphetamine | | | | |
| Ecstasy | | | | |

**Electronics if Applicable:**
Age at First Video Game: _____ Hours per day on electronics: _____
Age of First Cell Phone: _____ Do you miss meals with the family: _____
Age of First TV in Bedroom: _____ Do you get upset when you cannot have it: _____
Any loss of sleep due to electronics: _____

**Child's Activities of Daily Living (ADL):**
Bath daily: _____ Dress Self: _____ Toilet Hygiene: _____ Cleaning Room: _____
Brush Teeth Daily: _____ Tie Shoes: _____ Knows Emergency Contact: _____
Brush Hair Daily: _____ Feed Self: _____ Meal Prep: _____ Care for Pet: _____

## Is there anything else you would like us to know about you?