Intake Questionnaire

Name: _____ Date: _____

Please rate the severity of current symptoms using this rating scale:

1-None 2-Mild 3-Moderate 4-Severe

Sleep Disturbance Obsessions/ Compulsions Physical Pain

Appetite Disturbance Phobias Grieving

Episodic Crying Mood Swings Substance Abuse

Low Energy Irritability Eating Disorder

Depressed Mood Anger/ Temper Co-worker Conflict

Poor Concentration Aggressive Behavior Family Issues

Stress/Anxiety/Worry Homicidal Thoughts Relationship Conflict

Panic Attacks Suicidal Ideation Stress-Work/Home

Low Self-esteem Cut or Hurt Self Academic Problems

Memory Loss Sexual Problems Other

How long have you been experiencing the problem(s) that made you decide to get counseling?

Number of Days: ___ Number of Weeks: _____ Number of Months: _____ Number of Years: _____

My most serious problem is:

What do you hope to accomplish in seeking assistance at this time?

Do you have current significant health conditions or concerns?

If yes, description:

Are you currently taking any medications?

If yes, description:

Life / Work / Relationships

My daily life is full of things that keep me interested.

Do you exercise regularly? _____minutes _____ hours per week

How long does it take you to fall asleep?

When you were a child, did you feel abused or neglected by parent(s)?

Have you ever had your driver's license suspended or revoked?

Do you have trouble relating to others?

Have you become so frustrated that you physically struck another person or object?

Have you ever been harmed or are you afraid of someone who is close to you?

Do you feel that you are shy or lack self-confidence?

Have you received counseling in the past?