



INTAKE QUESTIONNAIRE

Client Name: _____ D.O.B: _____ Age: _____

PRESENTING PROBLEM

Briefly describe what brings you in for services: _____

Approximately how long has this concern been bothering you?

___ Day ___ Week ___ Month ___ Several Months ___ Year

___ Several Years ___ Most of my Life ___ Other, explain: _____

How often does the behavior or concern occur? _____

How long does it last? _____

On a scale of 1-100 (Mild-Severe) How intense would you rate the concern? _____

Please circle indicators below that **apply to your presenting concern:**

Academic concerns

ADHD/Attention

Adjustment concerns

Alcohol or drugs

Anger management

Anxiety, fear, nervousness

Career/job concerns

Compulsive behavior

Concern w/ others wellness

Cultural concerns

Cutting/self injury

Depression

Discrimination

Eating concerns/body image

Emotional abuse

Episodes of manic behavior

Family difficulties

Financial concerns

Harassment

Identity/sense of self

Impulse control

Indecisiveness

Internet usage

Interpersonal concerns

Legal concerns

Loneliness

Loss, grief, death

Self-esteem

Medical/health concerns

Mood swings

Obsessive thoughts

Panic attacks

Paranoia

Phobias Physical abuse Procrastination
Relationship concerns Sexual abuse/assault Sexuality concerns
Sleep difficulties Spiritual/religious concerns Stress/tension
Suicidal thoughts Thoughts racing

Other Concerns: _____

Please rate how your concerns affect the following areas (Low 1 2 3 4 5 High)

___ Academic performance ___ Work performance ___ Emotional wellness
___ Social life ___ Daily routine ___ Relationships
___ Other: _____

MENTAL HEALTH HISTORY

Have you previously received counseling or therapy? If yes, for what and when? _____

Have you received a diagnosis from a mental health practitioner? If yes, what and when? _____

Are you currently receiving mental health services elsewhere? If yes, with whom? _____

Have you been prescribed psychotropic medication in the past? If yes, what and how much? _____

Are you currently taking any psychotropic medication? If yes, what and how much? _____

Have you been previously hospitalized for mental health concerns? If yes, when? _____

Have you ever had thoughts about harming yourself? _____

Have you ever purposely harmed yourself without suicidal intent? _____

Have you ever had suicidal thoughts? _____

Have you ever attempted suicide? _____

Have you ever seriously considered harming another person? _____

Have you ever intentionally physically harmed another person? _____

PHYSICAL HEALTH HISTORY

How is your current physical health? ___ Poor ___ Unsatisfactory ___ Satisfactory
___ Good ___ Excellent ___ Other: _____

Have you previously had any serious accidents, injuries, or illnesses? Please describe.

Are you currently taking any medications not mentioned above? Please describe. _____

Please list any persistent physical symptoms or physical health concerns (e.g., chronic pain, headaches, diabetes): _____

How often do you exercise? _____

How many hours of sleep do you receive each night: ___ Sunday ___ Monday
___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___ Saturday

Please describe any difficulty with sleeping patterns (e.g., too little, too much)

Please describe any difficulty with eating habits (e.g., too little, too much)

Please describe any additional difficulties not mentioned above: _____

FAMILY HISTORY

Marital status? Single Married Separated Divorced Widowed Remarried

How many years married? _____ How long have you been separated/divorced? _____

Children? Yes/No Ages _____

Who lives in the home? _____

Family strengths: _____

Family challenges: _____

Briefly describe a typical evening in your household: _____

Describe family history of psychiatric/psychological, academic, legal and substance abuse problems? _____

EDUCATIONAL/VOCATIONAL BACKGROUND

Education/Jobs

Describe employment difficulties: _____

When did these problems begin? _____

ADDITIONAL INFORMATION

How many people in your family can you really count on for emotional support? _____

Aside from family members, how many people can you really count on for friendship and emotional support? _____

What are your expectations for coming to this office? _____

Any additional information that would assist in working with you? _____

Is there any other problem or question that you would like addressed or any other area in which you need assistance? _____
