Intake Questionnaire

1. PLEASE ENTER YOUR CONTACT INFORMATION.

First Name: _____ Middle Initials: _____ Last Name: _____ Last 4 digits of SSN _____

Date of Birth: _____ Gender: ○ Female ○ Male

Marital Status: ○ Single ○ Married ○ Partner ○ Separated ○ Divorced ○ Widowed

Address: _____ Apt./Unit #: _____

City _____ State _____ Zip Code _____

Permission to Send Postal Mail (Please Initial) _____

Mobile Phone: _____ Permission to Leave Message (Please Initial) _____

Home Phone: _____ Permission to Leave Message (Please Initial) _____

Work Phone: _____ Permission to Leave Message (Please Initial) _____

Email: _____ Permission to Email You (Please Initial) _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Do you have insurance?
☐ Yes ☐ No

Primary Insurance _____ Primary Insurance Member ID# _____

Who is the Primary Insurance Card Holder (if not self) _____ Primary Insurance Card Holder Date of Birth _____

Secondary Insurance _____ Secondary Insurance Card Member ID# _____

Who is the Secondary Insurance Card Holder (if not self) _____ Secondary Insurance Card Holder Date of Birth _____

Please indicate who will be financially responsible for any unpaid fees incurred? _____

Please sign below for permission to speak to whomever is financially responsible for your bill: _____

Presenting Problem

2. **Please tell us about how you found our center:**

- ☐ No-one (self-referral)
- ☐ Friend
- ☐ Family member
- ☐ Partner
- ☐ Co-worker
- ☐ Insurance Company
- ☐ Other (specify below)

3. **Please describe what has led you to seek Counseling now:**

_____

_____

_____

_____

4. **How long has this been a problem for you?**

_____

5. **What is your stress level?**

- ○ Low
- ○ Average
- ○ Considerable
- ○ Unbearable

6. **What are the major causes of your stress? (Check all that apply).**

- ☐ Marital
- ☐ Financial
- ☐ Career
- ☐ Family
- ☐ Health
- ☐ Unfulfilled expectations
- ☐ Substance use

7. **How are you feeling today? (Check all that apply).**

- ☐ Happy
- ☐ Depressed
- ☐ Sad
- ☐ Anxious
- ☐ Angry
- ☐ Irritable
- ☐ Elated
- ☐ Larger than life
- ☐ Calm

8. **Have you been feeling suicidal in the past two weeks?**

- ○ Yes
- ○ No

9. **Are you experiencing any thoughts or feelings of wanting to harm yourself or kill yourself today? (Please explain):**

_____

10. **Are you experiencing any thoughts or feelings of wanting to harm someone or kill someone today? (Please explain):**

_____

11. **Please give us a brief description of how long you have been experiencing your presenting problem:**

_____

Medical History

12. Please describe any prior psychiatric history (visits to psychiatrist, medication or hospitalization) or any prior therapy:

_____

13. Please describe any serious hospitalizations or accidents you went through:

	Date	Age	Reason
1			
2			

14. Please describe any trauma you have experienced in your life (car accident, head trauma, witnessing someone die, knowing someone who committed suicide, or domestic violence):

_____

15. Have you ever experienced the following:

- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Verbal Abuse
- ☐ Emotional/Mental Abuse

16. Who abused you? How long ago?

_____

17. Do you have any family members with the following conditions? (Check all that apply and indicate which family member).

- ☐ Depression
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Suicide Attempt or Completion

18. Please tell us about any medical conditions you have:

_____

19. Which medications (psychotropic or not) are you currently taking?

	Medication	Dosage	Since when?	Adverse effects
1				
2				

20. If you are currently under care of a Physician, please specify:

	Physician	Condition	Treatment
1			

Please sign if you consent to have our office contact your primary care physician for documentation:

_____

Signature

21. If you are currently under care of a Psychiatrist, please specify:

	Physician	Condition	Treatment
1			

Please sign if you consent to have our office contact your psychiatrist for documentation:

_____

Signature

Substance Use History

22. Do you have any difficulties with the following (check all that apply):

- ☐ Alcohol
- ☐ Drugs
- ☐ Food

23. Substance usage status

- ○ No history of abuse
- ○ Active abuse
- ○ Early partial remission
- ○ Early full remission
- ○ Sustained partial remission
- ○ Sustained full remission

24. Which - if any - of these substances do you currently use or have used in the past? Please use the box to indicate your age at first use and age at last use. (E.g.: Alcohol - 16, 30)

☐ Alcohol	☐ Amphetemines	☐ Barbiturates/Owners
_____	_____	_____
☐ Caffeine	☐ Cocaine	☐ Crack cocaine
_____	_____	_____
☐ Hallucinogens (e.g., LSD)	☐ Inhalants (e.g., glue, gas)	☐ Marijuana or hashish
_____	_____	_____
☐ Nicotine/cigaretters	☐ PCP	☐ Other (please specify)
_____	_____	_____

25. If any, which have been the consequences of substance abuse in your life? Please use the box below to dissert about such consequences:

- ☐ Arrests
- ☐ Assaults
- ☐ Binges
- ☐ Blackouts
- ☐ Hangovers
- ☐ Job loss
- ☐ Loss of control
- ☐ Medical conditions
- ☐ Overdose
- ☐ Relationship conflicts
- ☐ Seizures
- ☐ Sleep disturbance
- ☐ Suicidal impulse
- ☐ Tolerance changes
- ☐ Withdrawal symptoms
- ☐ Other (please specify)

26. **Is there a history of alcohol/drug abuse in your family? Please use the box below to indicate the type of drugs and if the abuse is active or in remission:**

- ☐ No-one
- ☐ Father
- ☐ Mother
- ☐ Sibling(s)
- ☐ Granparent(s)
- ☐ Stepparent (live-in)
- ☐ Uncle(s)/Aunts
- ☐ Spouse/Significant other
- ☐ Children
- ☐ Other (please specify)

Family History

27. **Presence of family during your childhood:**

	Present entire childhood	Present part of childhood	Not present at all	Don't have
Mother				
Father				
Stepmother				
Stepfather				
Brother(s)				
Sister(s)				

28. **Please describe your childhood family experience:**

- ○ Outstanding home environment
- ○ Normal home environment
- ○ Chaotic home environment
- ○ Witnessed physical/verbal/sexual abuse toward others
- ○ Experienced physical/verbal/sexual abuse from others
- ○ Other (please specify)

29. **Describe any past or current significant issues in your immediate family relationships:**

_____

_____

_____

_____

30. **Current relationship satisfaction:**

- ○ Very satisfied
- ○ Satisfied
- ○ Somewhat satisfied
- ○ Dissatisfied
- ○ Very dissatisfied

31. **Describe any past or current significant issues in your intimate relationships:**

_____

_____

_____

_____

32. List all persons currently living in your household:

	Name	Age	Sex	Relationship to you
1				
2				

33. What is your current living situation? Check all that apply:

- ☐ Housing adequate
- ☐ Homeless
- ☐ Housing overcrowded
- ☐ Dependent on others for housing
- ☐ Housing dangerous/deteriorating
- ☐ Living companions dysfunctional

Lifestyle

34. What support do you have in your life (Check all that apply).

- ☐ Family
- ☐ Friends
- ☐ School
- ☐ Work
- ☐ Religious Affiliation
- ☐ Social Activities

35. Your habits:

	How much?
Smoking	
Alcohol	
Recreational drugs	
Coffee	
Sleeping pills	
Laxatives / Purgatives	

36. What is your current employment situation? Check all that apply:

- ☐ Employed and satisfied
- ☐ Employed but dissatisfied
- ☐ Unemployed
- ☐ Coworker conflicts
- ☐ Supervisor conflicts
- ☐ Unstable work history
- ☐ Disabled

37. How is your social interaction? Check all that apply:

- ☐ Normal social interaction
- ☐ Isolates self
- ☐ Very shy
- ☐ Alienates self
- ☐ Inappropriate sex play
- ☐ Dominates others
- ☐ Associates with acting-out peers
- ☐ Other (specify below)

38. What is your current financial situation? Check all that apply:

- ☐ No current financial problems
- ☐ Large indebtedness
- ☐ Poverty or below-poverty income
- ☐ Impulsive spending
- ☐ Relationship conflicts over finances
- ☐ Other (please specify)

39. What is your legal situation? Check all that apply:

- ☐ No legal problems
- ☐ Now on parole / probation
- ☐ Arrest(s) not substance-related
- ☐ Arrest(s) substance-related
- ☐ Court ordered this treatment
- ☐ Jail/prison (specify how many times and total time imprisoned)
- ☐ Other (please specify)
- ☐ Jail/prison (specify how many times and total time spent)

40. How is your intellectual / academic functioning? Check all that apply:

- ☐ Normal intelligence
- ☐ High intelligence
- ☐ Learning problems
- ☐ Authority conflicts
- ☐ Attention problems
- ☐ Underachieving
- ☐ Mild retardation
- ☐ Moderate retardation
- ☐ Severe retardation
- ☐ Other (please specify)

41. What are your passions and leisure pursuits?

_____

_____

_____

_____

42. Current symptoms checklist. Rate intensity of symptoms currently present:

	None	Mild	Moderate	Severe
Aggressive Behaviors				
Agitation				
Anorexia				
Anxiety				
Appetite Disturbance				
Bingeing / Purging				
Conduct Problems				
Delusions				
Depressed Mood				
Elevated Mood				
Emotional Trauma Perpetrator				
Emotional Trauma Victim				

Fatigue / Low energy				
Grief				
Guilt				
Hallucinations				
Hopelessness				
Hyperactivity				
Irritability				
Mood swings				
Obsessions / Compulsions				
Oppositional behavior				
Panic attacks				
Paranoid ideation				
Phobias				
Physical trauma perpetrator				
Physical trauma victim				
Poor concentration				
Poor grooming				
Psychomotor retardation				
Self-multilation				
Sexual dysfunction				
Sexual trauma perpetrator				
Sexual trauma victim				
Significant weight gain/loss				
Sleep disturbance				
Social isolation				
Substance abuse				
Worthlessness				

Please SIGN and Date here to indicate that the information provided above is accurate and complete:

_____

Signature

Therapist: Jodi L. Olmstead, LMHC (FL #MH 12574)

_____

Signature