INTAKE QUESTIONNAIRE

Nancy L. Hammond, LPC, LLC
4716 Ellsworth Avenue #116
Pittsburgh, PA 15213

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*			**Today's Date:**
Primary Care Physician:	**PCP Phone #:**	**Date of last physical:**	

PERSONAL HEALTH HISTORY				
How would you describe your overall health currently? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**				
When was the last time you saw a physician?				
What was the reason?				
Medical Conditions				
Date of Onset	Describe Illness, Diagnosis, Diseases			Treating Physician
Surgeries				
Year	Reason			Hospital
Hospitalizations				
Year	Reason			Hospital

HEALTH HABITS				
Exercise	Sedentary (No exercise) ☐			
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf) ☐			
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐			
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) ☐			
Caffeine	None ☐	Coffee ☐	Tea ☐	Cola ☐
	# of cups/cans per day?			
Tobacco	Do you use tobacco? ☐ Yes	☐ No		
	Cigarettes – pks. a day	Number of years	Or year quit	
Alcohol	Do you drink alcohol? ☐ Yes ☐ No	If so, average number of drinks per week		
Drugs	Do you currently use any kind of non-prescription drugs? ☐ Yes ☐ No			
	If so, name the substance(s) and how often you use.			
	Have you used any kind of non-prescription drugs in the past? ☐ Yes ☐ No			
	If so, name the substance(s) and how often you used.			
	If drug use was in the past, how long have you been sober?			

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FAMILY OF ORIGIN (biological family)				
First Name	**Current Age** (or indicate if deceased & year)	**HEALTH PROBLEMS**	**QUALITY OF RELATIONSHIP**	(If applicable) **ARE YOU OUT TO THEM?**
Mother _____				☐ Yes ☐ No
Father _____				☐ Yes ☐ No
Siblings _____	M ☐ F ☐ Non-binary ☐ Age _____			☐ Yes ☐ No
_____	M ☐ F ☐ Non-binary ☐ Age _____			☐ Yes ☐ No
_____	M ☐ F ☐ Non-binary ☐ Age _____			☐ Yes ☐ No

Household Members *Everyone currently living with you*				
Name	Relationship	Age	Relationship Status *(Strained, cooperative, supportive, etc.)*	(If applicable) Are you out to them?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Primary Support *All those you feel are part of your primary support network*				
Name	Relationship (Friend, Family, Coworker, Church Affiliation, etc.)	Age	Frequency of Interaction	*(If applicable)* Are you out to them?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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Social/Recreational Activities *Activities you currently enjoy/participate in*	
Activity	**How often do you participate in this activity?**

EMPLOYMENT HISTORY			
Age	Job	Length of Employment	Reason for Leaving

How would you rate your current job satisfaction? ☐ Very Satisfied ☐ Satisfied ☐ Unsatisfied

Do you have concerns in this area? ☐ Yes ☐ No

If yes, please explain:

What are you career goals or hopes?

SEXUAL HEALTH

Do you participate in unprotected sex?	☐ Always	☐ Sometimes	☐ Never
Do you participate in anonymous/casual sex?	☐ Always	☐ Sometimes	☐ Never
Do you have multiple partners?	☐ Always	☐ Sometimes	☐ Never
Do you use alcohol or other drugs while engaging in sex?	☐ Always	☐ Sometimes	☐ Never

Please use this space to mention anything that was not covered in this form that you think is important for me to know.