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# INTAKE QUESTIONNAIRE

**Date:**_____

**NAME:**_____ **SSN:**_____

**DOB:**_____ **AGE:**_____

**ADDRESS:** _____

_____

**PHONE:** Home:_____ **Is it ok to leave a phone message?** ___No ___Yes

Cell : _____ **Is it ok to leave a phone message?** ___No ___Yes

**Referred by:** Self Family Friend Doctor Counselor Advisor Administrator

Name/or Other_____

May I contact the person who referred you and inform them that you scheduled an appointment with me? ___No ___Yes

## Emergency Information:

**Name:** _____ **Relationship**_____

**Address:**_____

_____

**Phone: Home:**_____ **Cell:**_____

*If you are uncomfortable answering any questions on this form, you may leave them blank.*
*At our initial appointment we can review your answers in greater depth, help clarify your goals, and determine together an appropriate course of action.*

**Please describe yourself as fully <u>as you feel comfortable</u>:**

**Gender:**

____Male ____Female ____ Intersex ____Transgender
____ MTF
____ FTM

**Race / Ethnicity**

____ African / African-American
____ Arab / Arab-American
____ Asian Pacific Islander / Asian American
____ Caucasian, European-American
____ Chicano(a), Latino(a), Hispanic
____ Mexican / Mexican-American
____ Native American or Alaskan Native
____ Southeast Asian / Southeast Asian American
____Persian
____Biracial / Bicultural _____
____ Multiracial / Multicultural_____
____Other_____

**Relationship Status**

____ Single ____Married or Partnered ____Separated ____Divorced ____Widowed ____Other

**Sexual Orientation**

____Bi-Sexual ____Gay or Lesbian ____Heterosexual ____Queer ____Questioning

**Languages spoken**: _____

**Religious affiliation/spirituality:** _____

**Involvement:** None Some /irregular Active

**Do you identify as having a disability?** No Yes (please specify)_____

**<u>School Information:</u>**

**School Name:** _____ **Major:**_____

**Class:** Freshman Sophomore Junior Senior 5th Year Graduate Transfer Student

**School Status:** Full time Part time Continuing Education

**GPA** (if applicable): Current? _____ Last Semester? _____

**<u>Employment Information:</u>**

**Employer:** _____

**Employment:** Full time Part time # of Hours/week _____

**Residence:** With Family (specify with whom):

Alone Roommates Dorm Off-Campus Greek Other:_____

**PRESENTING COMPLAINT:**

Why are you coming in to see me ?

When did you start having a problem with this?

**CURRENT CONCERNS:**

Please mark all of the items below that you are concerned about and make any notes on the page that may help me understand these concerns better. Feel free to indicate which of these items you would especially like to work on in therapy.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect, cruelty to animals
- ❑ Adjusting to work/school
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Assertiveness
- ❑ Attention, concentration, distractibility
- ❑ Bipolar Disorder
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Coming out
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling

- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Life Transition – Specify:
- ❑ Loneliness
- ❑ Couple's conflict, distance/coldness, infidelity/affairs, repartnership, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oppression (e.g., racism, sexism, heterosexism)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems
- ❑ Self-centeredness
- ❑ Self-esteem/acceptance
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Transitions
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, dissatisfaction, ambition

- Any other concerns or issues:

  _____

- Which concern(s) do you most want help with?

  _____

Please check (or highlight or bold if completing on computer) all the following symptoms that you have experienced:

**☐ = Recent (within the last month)** **○ = Past (one month ago or longer)**

| | |
|---|---|
| ☐ ○ change in appetite | ☐ ○ feelings of restlessness |
| ☐ ○ significant weight gain/loss | ☐ ○ trembling or shaking |
| ☐ ○ change in mood | ☐ ○ accelerated heart rate |
| ☐ ○ irritability | ☐ ○ shortness of breath |
| ☐ ○ feelings of worthlessness | ☐ ○ sweating |
| ☐ ○ changes in sleeping patterns | ☐ ○ chest pain |
| ☐ ○ loss of energy | ☐ ○ feelings of choking |
| ☐ ○ loss of interest in activities | ☐ ○ nausea |
| ☐ ○ loss or decrease in sexual interest | ☐ ○ recurrent thoughts of death |
| ☐ ○ lost or irregular menstrual cycle | ☐ ○ recurrent thoughts of wanting to commit suicide |
| ☐ ○ increase of energy | ☐ ○ recurrent thoughts of harming others |
| ☐ ○ difficulty concentrating | ☐ ○ cutting, punching or burning myself |
| ☐ ○ nightmares | ☐ ○ seeing things that others do not |
| ☐ ○ substance abuse (alcohol or drugs) | ☐ ○ hearing voices that others do not |
| ☐ ○ problems with attention, motivation, memory | ☐ ○ paranoid thoughts |
| ☐ ○ recurrent and excessive anxiety or worry | |

**COUNSELING HISTORY:**

Have you ever sought counseling for this or other concerns in the past? ___No ___Yes

If yes, briefly describe.

**PLEASE DESCRIBE YOUR GOALS FOR THERAPY:**