

Intake Questionnaire – Page 1

Today's Date: _____

Your Name: _____

Your Birthdate: _____ Age: _____

I am currently: Single Never married Widowed
 (Check any that currently apply to you, even if more than one.)
 Dating
 Cohabiting
 Married
 Separated
 Divorced

Have you been married previously (not counting at present)?
 Yes No If yes, how many times? _____

Do you have biological children of your own? Yes No
 If yes, how many children do you have? _____
 How many of your bio-children live with you? _____

Do you have step-children? Yes No
 If yes, how many step-children do you have? _____
 How many of your step-children live with you? _____

Education: Some high school High school
 (highest Technical / Trades 2-year associate degree
 level) Some undergraduate college or university
 Undergraduate degree Some graduate level
 Graduate degree: _____

Income: \$0-30,000 \$31-60K \$61-90K
 (household annual) \$91-120K \$120-150K \$150K +

Current Occupation: _____
 Years at Current Job: _____ Hrs per week: _____
 Do you enjoy your work? A lot Moderately Very little
 Career Goals: _____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over **the past two weeks**.

(Circle a number)

1. Feeling sad, down or depressed	0 1 2 3 4
2. Avoiding certain people or places	0 1 2 3 4
3. Loss of interest in activities I normally enjoy	0 1 2 3 4
4. Low energy/feeling tired	0 1 2 3 4
5. Sleep problems (insomnia, not staying asleep, or early waking)	0 1 2 3 4
6. Eating too much or too little	0 1 2 3 4
7. Not able to think clearly	0 1 2 3 4
8. Feeling no pleasure or joy in life	0 1 2 3 4
9. Anxiety attacks	0 1 2 3 4
10. Worrying about things	0 1 2 3 4
11. Angry outbursts	0 1 2 3 4
12. Low self-esteem or low self-confidence	0 1 2 3 4
13. Feeling guilty	0 1 2 3 4
14. Feeling too stressed	0 1 2 3 4
15. Thoughts of suicide	0 1 2 3 4
16. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0 1 2 3 4
17. Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0 1 2 3 4
18. Not getting my work done	0 1 2 3 4
19. Feeling unhappy with my workplace	0 1 2 3 4

If you are in a relationship with a spouse, boyfriend, girlfriend or partner, please rate how much you have experienced each of these additional six symptoms in your relationship over **the past two weeks**. If you are single, circle all 0's in the next six statements and enter the total of 1 through 25 in the box below.

(Circle a number)

20. Not talking to each other	0 1 2 3 4
21. Having bad arguments	0 1 2 3 4
22. Lack of trust between us	0 1 2 3 4
23. Feeling lonely in the relationship	0 1 2 3 4
24. Lack of affection and caring between us	0 1 2 3 4

Medical: Do you have any medical problems? Yes No
 If yes, please list them: _____

Do you take any prescription **Medications**? Yes No

If yes, please list them:

<i>Medication</i>	<i>Dose</i>	<i>Purpose</i>	<i>Since</i>

Do you **Exercise**? Yes No If yes, what do you do?

Do you drink **alcohol**? Yes No

If yes, estimate how many times you typically drink in a month (i.e. how many drinking occasions): _____

Estimate how many drinks you typically drink per occasion (estimate your range if it varies): _____

Do you **smoke** tobacco? Yes No

If yes, please estimate quantity per day: _____

Do you drink **coffee/ tea**? Yes No

If yes, please estimate quantity per day: _____

Do you use any **illicit drugs**? Yes No

If yes, please specify: _____

If you drink alcohol or use illicit drugs, please answer the following questions:

A. Have you ever thought you should **Cut Back** on your drinking/ drug use? Yes No

B. Have people **Annoyed** you by criticizing your drinking/ drug use? Yes No

C. Have you ever felt bad or **Guilty** about your drinking/ drug use? Yes No

D. Have you ever had a drink / used drugs in the morning (**Eye opener**) to steady your nerves or to get rid of a hangover? Yes No

Are you concerned about the alcohol and/or drug use of anyone close to you? Yes No If yes, who?

REASONS FOR SEEKING COUNSELING

Check those that apply (*using the left column*). If you check more than one, please select your top three and rank them (*using the right column*) from highest to lowest in terms of the priority you place on resolving them (1=highest priority, 2=second highest, 3=third highest).

- | | |
|--|-------|
| (√) (Check all that apply) | Rank |
| ___ Depressed Mood | _____ |
| ___ Anxiety | _____ |
| ___ Anger Management | _____ |
| ___ Self-Esteem or Confidence | _____ |
| ___ Social Difficulties | _____ |
| ___ Stress Management | _____ |
| ___ Substance Abuse (Alcohol/Drugs) | _____ |
| ___ Gambling Difficulties | _____ |
| ___ Other Addictions (i.e. Porn, Sex, Shopping) | _____ |
| ___ Eating Disorder | _____ |
| ___ Weight Management / Body Image | _____ |
| ___ Spiritual Problems | _____ |
| ___ Bereavement/ Loss | _____ |
| ___ Work problems | _____ |
| ___ Education/ Career Concerns | _____ |
| ___ Financial Concerns | _____ |
| ___ Legal Concerns | _____ |
| ___ Medical Issues | _____ |
| ___ Domestic Violence or Abuse (Current) | _____ |
| ___ Premarital Counselling | _____ |
| ___ Communication Problems/Relationship Conflict | _____ |
| ___ Sexual Intimacy Concerns | _____ |
| ___ Emotional or Sexual Infidelity/affairs | _____ |
| ___ Emotionally disconnected from spouse/partner | _____ |
| ___ Other Marital/Relationship Concerns | _____ |
| ___ Separation / Divorce / Relationship Break-Up | _____ |
| ___ Custody Concerns | _____ |
| ___ Parenting | _____ |
| ___ Parent-Adult Child Relations | _____ |
| ___ Blended Family Issues | _____ |
| ___ Family Conflict | _____ |
| ___ Child – Behavioral Problems | _____ |
| ___ Child – Mood / Anxiety Problems | _____ |
| ___ Child – Academic Problems | _____ |
| ___ Child – Social/ Relational Problems | _____ |
| ___ Other _____ | _____ |

PREVIOUS TREATMENT

Have you participated in therapy or counseling in the past?

- Yes No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

Who do you turn to for social support (e.g. for encouragement, advice, friendship, etc.)?

Are there any organizations or agencies that you are currently receiving assistance or support from? Yes No If yes, please specify: _____

EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL OR HEALTH DIFFICULTIES

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

- | | | |
|---|------------|-------|
| <input type="checkbox"/> Depression | Who? When? | _____ |
| <input type="checkbox"/> Bipolar Disorder | | _____ |
| <input type="checkbox"/> Schizophrenia | | _____ |
| <input type="checkbox"/> Other psychiatric disorders (i.e. psychosis, hallucinations) | | _____ |
| <input type="checkbox"/> Suicide | | _____ |
| <input type="checkbox"/> Physical / Sexual Abuse | | _____ |
| <input type="checkbox"/> Substance Abuse (Alcohol/Drugs) | | _____ |
| <input type="checkbox"/> Autism/Asperger's Syndrome | | _____ |
| <input type="checkbox"/> Eating Disorder | | _____ |
| <input type="checkbox"/> Chronic Illness (please specify illness) | | _____ |
| <input type="checkbox"/> Accidental or Untimely Death | | _____ |
| <input type="checkbox"/> ADHD or Learning Disorders | | _____ |
| <input type="checkbox"/> Other | | _____ |

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for me to know:
