

# Intake Questionnaire

## Confidential

Please fill out this intake form to the best of your ability. All material contained in this form will remain strictly confidential.

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years of age):

\_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_)\_\_\_\_\_ Okay to leave messages? Y N

Cell/Other Phone: (\_\_\_\_)\_\_\_\_\_ Okay to leave messages? Y N

Email: \_\_\_\_\_ Okay to Email? Y N

*\* Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Relationship/Marital Status (please circle):

In Relationship      Never Married      Domestic Partnership      Married  
Separated      Divorced      Widowed

Cultural and/or Ethnic Identification: \_\_\_\_\_

Spiritual and/or Religious Identification: \_\_\_\_\_

Please list any children with age(s): \_\_\_\_\_

\_\_\_\_\_

Others living in the home: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(Name) (Phone)

Education: \_\_\_\_\_

Occupation/Employment: \_\_\_\_\_

How many hours of work per week? \_\_\_\_\_

Satisfaction level with work/occupation/employment: \_\_\_\_\_

\_\_\_\_\_

**Present Concern(s)**

Please describe the reason(s) for seeking counseling (include date the concern started):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**History**

**Past Counseling or Mental Health Services:**

Psychological or psychiatric treatment of any kind before? Y N

What type of care was received? Outpatient \_\_\_\_\_ Inpatient \_\_\_\_\_

When was the treatment? \_\_\_\_\_

How long was the treatment? \_\_\_\_\_

Was there prescribed medication? Y N N/A

If yes, what was prescribed (include dosages if known)? \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any prescription medication? Y      N      N/A

If so, what type (include dosages if known): \_\_\_\_\_

Family history of psychological or psychiatric treatment: \_\_\_\_\_

**Symptoms:**

Please check if any of the following symptoms/problems/complaints are affecting you:

- Eating/Appetite concerns (i.e. lack of appetite, eating too much or too little)
- Sleeping difficulties (i.e. falling or staying asleep)
- Decreased energy/Fatigue
- Stress
- Muscle tension
- Unable to relax
- Depression
- Feeling alone
- Trouble with daily activities
- Isolation
- Sexual concerns
- Loss of interest in activities
- Change in social interests
- Tearfulness
- Hopelessness/Helplessness
- Decreased attention span
- Inattentive/Distractible
- Memory concerns
- Difficulty planning ahead
- Opposition
- Anger outbursts
- Impulse control (i.e. difficulty controlling behavior)
- Mood changes
- Anxiousness/Nervousness
- Worry/Fear
- Stealing
- Lying
- Legal problems
- Money and financial concerns
- Housing difficulties

- Panic attacks
- Rapid heart rate
- Dizziness
- Fainting
- Numbness or tingling
- Phobia
- Sweating
- Trouble breathing
- Flashbacks of traumatic event
- Nightmares
- Racing thoughts
- Hearing voices
- Seeing things
- Illness or physical health problems
- Being a caregiver
- Spiritual or Religious concerns
- Conflict with friends, co-workers, and/or significant other
- Separation from loved one
- Grief and/or loss
- Death of a friend, family member, and/or significant other
- Suicidal ideation
- Suicide attempt
- Self-harm
- Homicidal ideation
- Drug use/abuse
- Alcohol use/abuse
- Work/School concerns
- Marital/Relationship concerns
- Family concerns
- Friendships concerns
- Other concern(s) not listed \_\_\_\_\_

**Physical and Medical:**

How would you rate your current physical health? (please circle)

Poor    Unsatisfactory                      Satisfactory                      Good                      Very Good

Please list any specific health problems you are currently experiencing?

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*Sleep*

How many hours of sleep do you get a night on average? \_\_\_\_\_

Do you typically feel rested?     Y     N

Any concerns (i.e. falling and/or staying asleep)? \_\_\_\_\_

\_\_\_\_\_

*Eating and Nutrition*

How many meals do you eat a day on average? \_\_\_\_\_

Do you typically feel like you get enough nutrition?     Y     N

Any concerns (i.e. not getting enough or getting too many calories)? \_\_\_\_\_

\_\_\_\_\_

*Exercise*

Do you exercise or get physical activity on a consistent basis? Y     N

If so, how many hours a week? \_\_\_\_\_ Type of activity: \_\_\_\_\_

\_\_\_\_\_

Any concerns (i.e. injuries, inactivity, etc)? \_\_\_\_\_

\_\_\_\_\_

*Medical*

Major accidents, surgeries, medical problems, illnesses, and/or traumatic events

(include date(s)): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Under current medical treatment: Y     N     If so, why: \_\_\_\_\_

\_\_\_\_\_

Current medications: \_\_\_\_\_

Over the counter medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

*Substance Use*

Caffeine: Y N Type: \_\_\_\_\_ # of drinks per day \_\_\_\_\_

Tobacco product: Y N Type: \_\_\_\_\_ Use per day \_\_\_\_\_

Alcohol: Y N Type: \_\_\_\_\_ # of drinks per day \_\_\_\_\_ Week \_\_\_\_\_

Street drugs: Y N Type: \_\_\_\_\_ Amount \_\_\_\_\_ How often \_\_\_\_\_

Describe the impact of substance use on your life: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Past treatment for substance use (if any): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Family history of substance use (if any): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Relationship:**

*Romantic*

Are you currently in a romantic relationship? Y N If yes, for how long? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How would you describe your relationship? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Satisfaction level of relationship? \_\_\_\_\_

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Past significant romantic relationships and/or marriages: \_\_\_\_\_

*Sexual*

Is your sex life satisfactory? Y N      If not, what are your concerns \_\_\_\_\_

In my opinion sex is \_\_\_\_\_

*Family Structure*

Who do you currently live with and/or consider a part of your immediate family?

How would you describe your family? \_\_\_\_\_

*Family of Origin*

Siblings: Y N    If so name(s) & age(s) \_\_\_\_\_

How would you describe your family upbringing? \_\_\_\_\_

Significant events (I.e. divorce, abuse, etc.): \_\_\_\_\_

Current family or origin relationships (i.e. who are you close and in contact with?):

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*Friendships*

How would describe your friendships and/or social life? \_\_\_\_\_

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**Personal Interests:**

Please list some of your interests and/or hobbies: \_\_\_\_\_

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How is most of your free time occupied? \_\_\_\_\_

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What significant life changes or stressful events have you experienced recently?

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Please list a few of your strengths: \_\_\_\_\_

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Please list a few areas that you find challenging or consider weaknesses:

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What would you like to accomplish out of your time in counseling?

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Motivation for counseling: \_\_\_\_\_

\_\_\_\_\_

Other Information that you would like to provide: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Client/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Jessica Higgins, PhD, LPC

\_\_\_\_\_  
Date