INTAKE INTERVIEW QUESTIONS:

The following questions will help me better assist you in the counseling process. Your responses will increase my ability to be effective and to focus treatment. If for any reason you do not want to answer a question you may leave it blank.

Client Name _____ Date_____ Age _____

Who suggested you come to see me? _____
May I thank them for the referral _____ Yes _____ No

Previous Therapists or Psychiatrists

Name	Phone/Fax Number	May I contact them
_____	_____	_____ Yes _____ No
_____	_____	_____ Yes _____ No
_____	_____	_____ Yes _____ No

In general, did you have a good experience in treatment? _____ Yes _____ No
Why or why not? _____
_____

Have you ever gone to the hospital for mental health reasons? _____ Yes _____ No
If yes, where did you go? _____
If yes, approximate dates: _____

Have you ever gone to a hospital/inpatient facility for substance abuse reasons:
_____ Yes _____ No
If yes, where did you go? _____
If yes, approximate dates: _____

Do you currently have suicidal thoughts? _____ Yes _____ No
Have you ever attempted suicide? _____ Yes _____ No (#) _____ Times
Do you have thoughts or urges to harm others? _____ Yes _____ No
If yes, please explain _____

_____

What brings you to therapy at this time? Is there something specific, such as a particular event? Be as detailed as possible.

_____

_____

_____

In your own words, what do you hope to gain from being in counseling?

_____

_____

_____

What do you see as your strengths? (Couples please also identify relationship strengths).

_____

_____

_____

Family Background

Do you have any family members with psychiatric or psychological issues? If so, please describe.

_____

_____

_____

Medical Information

Please list your primary care physician as well as any other doctors who prescribe you medication.

_____ _____

Primary Care Physician's Name Phone Number

_____ _____

Prescribing Doctor's Name Phone Number

_____ _____

Prescribing Doctor's Name Phone Number

Current Drugs/medications/nutritional supplements that you are taking:

Medication Name	Reason for Medication	Dosage	Frequency

Do you smoke _____ No _____ Yes (#) _____ per day
Do you drink alcohol _____ No _____ Yes (# of drinks)_____ per week
Do you engage in recreational drug use? _____ No _____ Yes
Do you exercise? _____ Regularly _____ Occasionally _____ Rarely _____ Never

Please list any major illnesses, accidents, and/or hospitalizations within the last 5 years.

_____

_____

Please check any of the following you have experienced in the past six months.

☐ Increased Appetite
☐ Decreased Appetite
☐ Trouble Concentrating
☐ Difficulty Sleeping
☐ Excessive Sleep
☐ Low Motivation
☐ Isolation from Others
☐ Fatigue/Low Energy
☐ Low Self-Esteem
☐ Depressed Mood
☐ Tearful or Crying Spells
☐ Anxiety
☐ Fear
☐ Hopelessness
☐ Panic
☐ Other _____

Please check any of the following that apply.

☐ Headache
☐ High Blood Pressure
☐ Gastritis or Esophagitis
☐ Hormone Related Problems
☐ Head Injury
☐ Angina or Chest Pain
☐ Irritable Bowel
☐ Chronic Pain
☐ Loss of Consciousness
☐ Heart Attack
☐ Bone or Joint Problems
☐ Seizures
☐ Kidney Related Issues
☐ Chronic Fatigue
☐ Dizziness
☐ Faintness
☐ Heart Valve Problems
☐ Urinary Tract Problems
☐ Asthma
☐ Arthritis
☐ Thyroid Issues
☐ HIV/AIDS
☐ Cancer
☐ Other

Thank you for taking the time to complete this form. It will help me take better care of you.