Intake Questionnaire

Please fill this out to the best of your ability prior to your first appointment. If you are filling this out for a minor, please answer these questions about the minor and not about yourself.

Name of person filling out form: _____ Name of client: _____
Relationship to client: _____ Client DOB: _____

Reason(s) for seeking therapy services at this time:

_____

_____

_____

Description of symptoms (check all that apply):

- ▫ Anxiety/excessive worry
- ▫ Specific fears/phobias
- ▫ Obsessive thoughts
- ▫ Intrusive thoughts
- ▫ Avoidance
- ▫ Restlessness
- ▫ Compulsive behaviors
- ▫ Panic attacks
- ▫ Trouble concentrating
- ▫ Irritability
- ▫ Trouble falling/staying asleep
- ▫ Over-sleeping
- ▫ Nightmares
- ▫ Impulsive behaviors
- ▫ Isolation
- ▫ Fatigue/low energy
- ▫ Low self-esteem
- ▫ Depressed mood
- ▫ Hopelessness
- ▫ Lack of interest/joy in activities
- ▫ Thoughts of death/suicidal ideation
- ▫ Dissociation
- ▫ Hallucinations
- ▫ Delusions
- ▫ Paranoia
- ▫ Eating/exercise issues
- ▫ Homicidal ideation
- ▫ Hair-pulling
- ▫ Skin-picking
- ▫ Other (explain): _____

_____

_____

_____

_____

_____

Have you ever attempted suicide?

- ▫ Yes (more than 6 months ago)
- ▫ Yes (less than 6 months ago)
- ▫ No

Have you ever harmed yourself on purpose (cutting, burning, scratching, head-banging, etc)?

- ▫ Yes (more than 6 months ago)
- ▫ Yes (less than 6 months ago)
- ▫ No

Do you have any history of maltreatment, trauma, or abuse?

- ▫ Yes (past)
- ▫ Yes (current)
- ▫ No

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Have you been hospitalized for mental health/psychiatric reasons?

- ▫ Yes (more than 6 months ago)
- ▫ Yes (less than 6 months ago)
- ▫ No

Do you have a history of mental health treatment?

- ▫ Yes (please describe dates, providers, reasons): _____
  _____
  _____
  _____
- ▫ No

Current medications: _____
_____
_____

Current medication prescriber (if applicable): _____
_____
_____

Physical health history:

- ▫ Head trauma
- ▫ Loss of consciousness
- ▫ Seizures
- ▫ Heart concerns
- ▫ Surgeries
- ▫ Other (explain): _____
  _____
  _____
- ▫ None

Current primary care physician: _____
_____
_____

Have you ever had treatment for a drug/alcohol problems?

- ▫ Yes (please explain dates and types of treatment): _____
  _____
  _____
  _____
- ▫ No

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Do you currently use drugs and/or alcohol?

- ▫ Yes (please explain how much, how often, and if this impacts your mental health symptoms): _____
  _____
  _____
- ▫ No

CAGE-AID:
Please answer the following 4 questions thinking about the last three months:

1. Have you ever felt you ought to cut down on your drinking or drug use?
   - ▫ Yes
   - ▫ No
2. Have people annoyed you by criticizing your drinking or drug use?
   - ▫ Yes
   - ▫ No
3. Have you ever felt bad or guilty about your drinking or drug use?
   - ▫ Yes
   - ▫ No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?
   - ▫ Yes
   - ▫ No

Family health history (physical, chemical, mental health): _____
_____
_____
_____
_____

Developmental history: _____
_____
_____
_____

Description of childhood: _____
_____
_____
_____

Legal concerns/history: _____
_____
_____

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Current living situation (home, apartment, alone, with family, with roommates, etc): _____

_____

_____

Level of education:

- ▫ Preschool/not of school age
- ▫ Elementary school (grade: _____)
- ▫ Middle school (grade: _____)
- ▫ High school (grade: _____)
- ▫ High school diploma
- ▫ GED
- ▫ Trade/technical school
- ▫ College (year: _____)
- ▫ College graduate
- ▫ Graduate school
- ▫ Graduate school graduate (degree: _____)
- ▫ Other: explain: _____

  _____

  _____

Current occupation (if applicable): _____

_____

_____

Cultural influences and spiritual/religious beliefs: _____

_____

_____

Strengths and resources: _____

_____

_____

Goals for therapy: _____

_____

_____

_____

_____ _____

Client (or parent/guardian if client is a minor) Signature Date