Intake Questionnaire for Individual Psychotherapy

** indicates a required field*

*** What brings you to counseling at this time? Be as detailed as you can.**

*** What are your goals for counseling?**

*** Have you seen a mental health professional before?**

- Yes
- No

*** Specify all medications and supplements you are presently taking and for what reason. (Put "none" if you are not taking any.)**

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

*** Do you drink alcohol?**

- Yes
- No

*** Do you use recreational drugs?**

- Yes
- No

*** Do you have, or have you ever had, suicidal thoughts or attempted suicide?**

- Yes
- No

*** Do you have thoughts or urges to harm others?**

- Yes
- No

*** Have you ever been hospitalized for a psychiatric issue?**

- Yes
- No

*** Is there a history of mental illness in your family?**

- Yes
- No

*** If you are in a romantic relationship, please describe the nature of the relationship and months or years together.**

*** Describe your current living situation. Do you live alone, with others, with family, etc.?**

*** What is your level of education, including highest grade/degree completed and type of degree?**

*** What is your current occupation? What do you do? How long have you been doing it?**

*** 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
- [ ] Excessive anger
- [ ] Alcohol or drug craving
- [ ] Eating problems
- [ ] Hearing voices that others do not hear
- [ ] Seeing things others do not see
- [ ] Physical abuse
- [ ] Sexual abuse
- [ ] Emotional/verbal abuse
- [ ] Sexual problems
- [ ] Relationship problems
- [ ] Family conflict
- [ ] 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
- [ ] Fibromyalgia
- [ ] Numbness & tingling
- [ ] Shortness of breath
- [ ] Diabetes
- [ ] Hepatitis
- [ ] Asthma
- [ ] Arthritis
- [ ] Thyroid issues
- [ ] HIV/AIDS
- [ ] Cancer
- [ ] Other

What else would you like your provider to know?