Standard Intake Questionnaire

What brings you to counseling at this time?
Is there something specific, such as a particular event? Be as detailed as you can.
What are your goals for counseling?
Have you seen a mental health professional before?
☐ Yes ☐ No
If yes, please specify dates, reason for counseling, and your experience.
Specify all medications and supplements you are presently taking and for what reason.
If taking prescription medication, who is your prescribing MD?
Type of MD:
Name:
Phone:

Who is your primary care physician?

Type of MD:

Name:

Phone:

Do you drink alcohol?

☐ Yes ☐ No

If yes, please specify type, amount, and frequency:

Do you use recreational drugs?

☐ Yes ☐ No

If yes, please specify type, amount, and frequency:

Do you have suicidal thoughts?

☐ Yes ☐ No

If yes, please provide more details:

Do you have thoughts or urges to harm others?

☐ Yes ☐ No

If yes, please provide more details:

Have you ever been hospitalized for a psychiatric issue?

☐ Yes ☐ No

If yes, please provide more details:

Indicate where, when, and why.

Is there a history of mental illness in your family?

☐ Yes ☐ No

If yes, please provide more details:

If you are in a 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?

Indicate highest grade/degree and type of degree.

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

Check all that apply (in the past 6 months):	
☐ Increased appetite	☐ Depressed mood
☐ Decreased appetite	☐ Tearful or crying spells
☐ Trouble concentrating	☐ Anxiety
☐ Difficulty sleeping	☐ Fear
☐ Excessive sleep	☐ Hopelessness
☐ Low motivation	☐ Panic
☐ Isolation from others	☐ Other (specify):
☐ Fatigue/low energy	

Check all that apply:	
☐ Headache	☐ Faintness
☐ High blood pressure	☐ Heart valve problems
☐ Gastritis or esophagitis	☐ Urinary tract problems
☐ Hormone-related problems	☐ Fibromyalgia
☐ Head injury	☐ Numbness and tingling
☐ Angina or chest pain	☐ Shortness of breath
☐ Irritable bowel	☐ Diabetes
☐ Chronic pain	☐ Hepatitis
☐ Loss of consciousness	☐ Asthma
☐ Heart attack	☐ Arthritis
☐ Bone or joint problems	☐ Thyroid issues
☐ Seizures	☐ HIV/AIDS
☐ Kidney-related issues	☐ Cancer
☐ Chronic fatigue	☐ Other (specify):
☐ Dizziness	

What else would you like me to know?