Psychotherapy Intake Questionnaire

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Full Legal Name:______________________________________ **Name you want to be called:** _______________
Gender (legal): __________ **Gender (identity):** ______________ **Preferred Pronoun(s)**____________________
Please print clearly and complete all information. **Date:** ____________**Date of Birth:** __________

1. What is the reason you are seeking therapy?
____
2. Who referred you? (Circle answer) Self | Family | Physician | Employer | School | Court | Other
3. Their name ____
4. When did this problem start?____
5. What might be contributing to the problem?____

(Circle the Statements you identify with lately within each of the 4 Columns below)

Physical Feeling	Emotional Feeling	Thinking	Behavior
• Hair Falling Out • Low Back Pain • Headache • High Blood Pressure • Stomach Aches or Heartburn • Loose Stool/Diarrhea or Constipation • Muscle Tension in Neck or Shoulders	• Stressed • Jealous • Envy		
• Frequent Urination • Numbness, Tingling, Cold Hands and Feet • Sweating • Heart Race • Shortness of Breath • Dry mouth • Difficulty Swallowing • Can't Relax When Want to	• Anxious • Easily Embarrassed • Scared/Fearful • Annoyed Easily/Irritable	• Uncontrolled Worry • Anticipating something bad might happen • Fear Embarrassing Myself • Need to Make Things "Just Right" • Perfectionism • Intrusive and Unpleasant Memories • Distressing Dreams • Repetitive Thoughts	• Repetitive Behaviors • Hoarding
• Sleeping too Much • Trouble Falling Asleep • Trouble Staying Asleep • Hard time getting started in the morning, then energy picks up. • Feeling Tired, Little Energy • Increased Appetite/Weight • Decreased Appetite/Weight • Loss of Sexual Interest • Problems with Sexual Function	• Guilt • Sadness • Crying • Depressed • Hopeless • Shameful	• Difficulty making decisions • Forgetfulness • Pessimism About the Future • Loss of Interest or Pleasure • Thinking I am a Failure or Worthless • Lots of Regrets • Thoughts of harm to Self • Wish I were dead • Thoughts of harm to Others	• Avoiding Social Activity • Not getting things done • Self-injury

• Not Needing Sleep
• Lots of Energy
	• Rapidly shifting Feelings
	• Euphoric (overly happy)
	• Angry
		• Poor Concentration
		• Inflated Self-Esteem
		• Talkative
		• Mind Racing/Lots of Ideas
		• Easily Distracted
		• Difficulty Organizing
			• Constantly on the Go
			• Excessive Pleasure on:
			  • Spending
			  • Sex
			  • Gambling
			• Other Risky Behavior
			• Impulsivity

	• Confused • Emptiness • No Pleasure	• Detachment from My Body • Thinking I am Inadequate • "Spacing out"	• Cutting or Hurting Myself • Lying • Difficulty Getting Along with Others
		• Suspiciousness • Thinking I have Supernatural Powers • Thinking there is Something Alive in My Body • Seeing or Hearing Things Others Don't	
	• Detached • Unable to feel for others	• Constant Thought About My Weight/Appearance	• Restricting Eating • Binge Eating

Current Stress Management Strategies

Strategy **(Please circle those which apply)**	**Nearly Every Day**	**Weekly**	**Once in a while**	
Reading				
Writing or Journaling				
Exercise (what do you do?)				
Physical Therapy or Chiropractor				
Yoga, Tai Chi, or Martial Arts (please circle which one)				
Socialize				
Pray				
Attend Church/Synagogue/Mosque				
Meditate, Guided Imagery, Progressive Relaxation				
Biofeedback,				
Support or "12 Step" Group				
Nature, hikes, canoe etc.				
Listen to Music, Dance (please circle which one)				
Perform Music, Create Art				
Watch Movies/Surf the Net/Computer Games				
Shop				
Gambling or Other Compulsive Behaviors				
What else? (please fill in)				

Past Mental Health History

6. Have you had mental health counseling or therapy in the past? Yes | No

7. Are you on, or have you been on, medications for mental health symptoms? Yes | No If yes, please list medication:

Name(s) of current medication(s)	Past Medication(s)

8. Have you been **hospitalized** for mental health problems? Yes | No If yes, estimate when and where.

____

____

9. Have you attempted to take your life, cut, burned or harmed yourself? Yes | No

10. Have you a history of harming others? Yes | No

Physical and Medical History

11. Primary Care Physician ____________________________ Works at ____________________________

12. Specialist(s) and clinic(s) ____

13. Are you currently having pain? Yes | No If yes, where? ____________________________________

14. What major **Medical problems** do you currently have, have had in the past?

Name of Medical Problem	Dates

Name of Medical Problem	Dates

15. **Family History of Major Medical Problems?** ____

Tobacco and Caffeine Use

16. Do you smoke? Yes | No If yes, how many packs a day? ________
17. How much caffeine do you use?
    - # of cups of coffee per day: ______
    - # of caffeinated pop or energy drinks per day ___

Alcohol and Drug Use

How old were you when you first had a drink? _____ years old

How many alcoholic drinks per week do you usually have? _______ drinks per week

(one drink = 1 beer, 1 glass of wine or 1 shot of hard liquor/mixed drink)

How many times in the past year have you had 5 or more drinks on one occasion? ___ times

How many blackouts have you had in your life? ____

Please circle best answer

Have you used street drugs or other people's prescribed medications?	Y N	
Have you ever felt you should cut down on your drinking or drug use?	Y N	
Have you ever had people annoy you by criticizing your drinking or drug use?	Y N	
Have you ever felt bad or guilty about your drinking or drug use?	Y N	
Have you ever had a drink or used drugs as an eye opener the first thing in the morning to steady your nerves, to get rid of a hangover or to get the day started?	Y N	How many? ____
Was there a time when …		
You used alcohol or other drugs weekly or more often?	Y N	
You spent a lot of time either: getting, using or feeling the effects of alcohol or other drugs?	Y N	
You kept using alcohol or other drugs even though it was causing social problems like fights or getting you intro trouble with other people?	Y N	
Your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events?	Y N	
You had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping or that you used alcohol or drugs to stop being sick or avoid withdrawal problems?	Y N	

18. Has anyone expressed concern about your drug or alcohol use? ________________________________
19. Have you ever had an assessment or treatment for any type of drug or alcohol use problem? If so, please describe (Include Inpatient, out-patient, detox) ____

Family and Social History

20. Where were you born and raised? ___________________
21. Did your mother have any problems with her pregnancy, labor or delivery? Yes | No
22. Did you have any delays with respect to crawling, walking, talking, learning to take care of yourself, separating from parents, going to school, making friends, etc. Yes | No

23. How many brothers and sisters did you have? ___ Brothers ___ Sisters. My place in birth order ____
24. Who were you raised by? ____
25. Were your parents separated or divorced? (circle one) Yes | No If so, how old were you ?______
26. Have you been the victim of physical, emotional or sexual abuse, trauma or neglect? Yes | No

27. a) What religion(s) were you raised into? ____
    b) Do you have any religious or spiritual practice now? ____

28. Please note below any mental health or hereditary problems in your current or biological family

Condition	Relation to you
Alcohol or Drug Problems	
Attention-Deficit Disorder	
Anxiety	
Bipolar Disorder (also called Manic Depression)	
Depression	

Condition	Relation to you
Learning Disabilities	
Obsessive Compulsive Disorder	
Post-Traumatic Stress Disorder	
Schizophrenia	
Suicide	
Other:	

29. What is your relationship status? (Please circle all that apply and indicate the number of years in the blank)
    Single ___ | Engaged ___ | Married ___ | Partnered ___ | Separated ___ | Divorced ___ | Widowed ___
30. How many children do you have? ____

31. Please list people currently living with you:

First Name	Age	Relationship to you	Occupation or School

32. Please list **other important and supportive** people in your life.

First Name	Age	Relation to you

33. What is the highest grade you completed in school? ______
34. Currently a Student at ____ □
35. Current work/financial status:
    Employed: Full-time | Part-time as ___________________________ Unemployed Since ___________
    Homemaker or Caregiver __ Retired __
    Disabled Since ________________ Government Assistance __ □
    □
36. Housing Problems? Yes | No
37. Military Status: None □ Active □ Reserve □ Honorable Discharge □ Other Discharge

38. Do you have involvement with any of the following people or services? (Check all that apply)
    County Social Worker___ Probation Officer___ Adult/Child Protection___ Attorney___