COUNSELING SOLUTIONS LLC

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Intake Questionnaire (Adult)

This questionnaire is designed to get to know you better and in order provide the best mental health services. Please complete this form as honestly and completely as you can and either bring with you for your first visit or you can email it to me at the above email address. All information provided in this questionnaire is confidential as required by state and federal law.

Date: _____ Date of Birth: _____

Name: _____ Age: _____

Address: _____ Phone: _____

_____ SSN: _____-_____-_____

E-Mail: _____ OK to contact? Ph: ___ Email: ___

*Emergency Contact: _____

Relationship: _____ Phone: _____

*Do you give Counseling Solutions, LLC permission to contact your Emergency Contact regarding presence and participation in therapy? _____ YES _____ NO

Signature: _____ Date: _____

You may revoke this consent to your Emergency Contact at any time through providing written notice to Counseling Solutions, LLC.

Describe what has brought you to seek counseling?

_____

_____

_____

Please list 3 goals you would like to accomplish in counseling?

1. _____
2. _____
3. _____

Current Symptoms Checklist: (check any symptoms present within the last 2 weeks)

( ) Depressed mood
( ) Racing thoughts
( ) Excessive worry
( ) Unable to enjoy activities
( ) Impulsivity
( ) Anxiety attacks
( ) Sleep pattern disturbance
( ) Increase risky behavior
( ) Avoidance
( ) Loss of interest
( ) Increased libido
( ) Hallucinations
( ) Concentration/forgetfulness
( ) Substance Use
( ) Decrease need for sleep
( ) Suspiciousness
( ) Change in appetite
( ) Excessive energy
( ) Excessive guilt
( ) Increased irritability
( ) Fatigue
( ) Crying spells
( ) Decreased libido
( ) Excessive Anger
( ) Self-Harm behaviors
( ) _____
( ) _____
( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

If YES, please answer the following.

If NO, please skip to the next section.

Do you currently feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

_____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is there method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

If yes, what did you do in this attempt and how long ago was your attempt? _____

_____

Medical History

Allergies_____

List ALL current prescription medications and how often you take them: (if none, write none): _____

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____

Current medical problems: _____

Past medical problems, non-psychiatric hospitalization, or surgeries: _____

_____

Your Exercise Level

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? ( ) 1-2 days ( ) 3-4 days ( ) 5+ days

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Past Psychiatric History

Outpatient treatment ( ) Yes ( ) No

How many times? ( ) 1-2 times ( ) 3-4 times ( ) 5+ times

Please describe when, by whom, and nature of treatment.

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No

How many times? ( ) 1-2 times ( ) 3-4 times ( ) 5+ times

Please describe reason for hospitalization, when, where, and for how long.

_____

_____

_____

Past Psychiatric Medications

Please indicate any past psychiatric medications you have taken. If you can't remember all the details, just write in what you do remember.

Medication Name	Dates	Dosage	Response/Side Effects

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Schizophrenia	( ) Yes ( ) No	Anger	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Post-traumatic stress	( ) Yes ( ) No	Suicide	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, which relative for each was diagnosed or treated? _____

_____

_____

Substance Use Treatment

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when?

_____

_____

Alcohol Use History

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

How old were you when you started drinking alcohol? _____

Do you have any side effects from not drinking alcohol? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

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

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Drug Use History

Have you used or experimented with any street drugs? ( ) Yes ( ) No

If yes, please fill out the following chart regarding use or experimentation (only fill in what applies).

Drug Name	Age Started	How often do you use?	Amount you use each time?	Last time you used this drug?	Side Effects if you stop using.
Methamphetamine					
Cocaine					
Stimulants (pills)					
Heroin					
LSD or Hallucinogens					
Marijuana					
Pain Killers (not prescribed)					
Other Prescription Medications					
Tranquilizers/Sleeping Pills					
Ecstasy					
Methadone					
Other:					
Other:					

If you abused prescription medications including pain killers, which ones and for how long?

_____

_____

If you indicated that you use Methadone or Marijuana, is your use part of a monitored treatment? ( ) Yes ( ) No

If yes, please describe type of treatment and where you receive treatment.

_____

_____

_____

How many caffeinated beverages do you drink a day?

Coffee _____ Sodas _____ Tea _____ Energy Drinks _____

Tobacco Use History

Do you currently smoke cigarettes? ( ) Yes ( ) No

If yes, how many cigarettes per day on average? _____

How many years have you smoked cigarettes? _____

If no, have you smoked cigarettes in the past? ( ) Yes ( ) No

If yes, how many cigarettes per day on average? _____

How many years did you smoke? _____ When did you quit? _____

Pipe, Cigars, or Chewing Tobacco Use History

Do you currently smoke a pipe, cigars or use chewing tobacco? ( ) Yes ( ) No

If yes, how often per day on average? _____ What kind do you use? _____

How many years have you smoked a pipe, cigars, or used chewing tobacco? _____

If no, have you smoked a pipe, cigars, or used chewing tobacco in the past? ( ) Yes ( ) No

If yes, how often per day on average? _____ What kind did you use? _____

How many years did you smoke a pipe, cigars, or use chewing tobacco? _____

When did you quit? _____

Other High Risk Behaviors

Gambling

Do you participate in gambling activities (i.e. attending casinos, play online, play the lottery)? ( ) Yes ( ) No

If Yes, how many times a week do you participate in these activities?

( ) 1-2 times ( ) 3-5 times ( ) 5-10 times

Please rate how severe your concerns are on a 0-10 scale (0 = not concerned at all, 5 = some concern, but I have my behaviors under control, and 10 = very concerned and I need treatment for this issue) _____

Shopping/Shoplifting

Do you find that you struggle with shopping or shoplifting behaviors? ( ) Yes ( ) No

If Yes, please rate how severe your concerns are on a 0-10 scale (0 = not concerned at all, 5 = some concern, but I have my behaviors under control, and 10 = very concerned and I need treatment for this issue) _____

Internet Usage

Do you find that you struggle with being on the internet or using the internet excessively (not work or school related)? ( ) Yes ( ) No

If Yes, how often during the week are you on the internet?

( ) 1-5 hours wk ( ) 5-10 hours wk ( ) 10-15 hours wk ( ) 15-20 hours wk ( ) 20+ hours wk

Please rate how severe your concerns are on a 0-10 scale (0 = not concerned at all, 5 = some concern, but I have my behaviors under control, and 10 = very concerned and I need treatment for this issue) _____

Eating Behaviors

Do you find that you struggle with eating and/or eating too much? ( ) Yes ( ) No

If Yes, please rate how severe your concerns are on a 0-10 scale (0 = not concerned at all, 5 = some concern, but I have my behaviors under control, and 10 = very concerned and I need treatment for this issue) _____

Legal History

Have you ever been arrested? ( ) Yes ( ) No How many times? _____

What was your arrest(s) for?

_____

_____

Were you incarcerated? ( ) Yes ( ) No How many times? _____

How Long? _____ Where _____

Do you have any pending legal problems? ( ) Yes ( ) No

If Yes, Please Explain:

_____

_____

_____

Family Background & Childhood History

Were you adopted? ( ) Yes ( ) No

If Yes, do you know your birth parents? ( ) Yes ( ) No

Where did you grow up? _____

Are your parents currently living? ( ) Yes ( ) No

If no, how long ago did they pass away? _____

Are your parents still married? ( ) Yes ( ) No

If no, how old were you when they divorced? _____

If your parents are divorced, who did you primarily live with? _____

Describe your father and your relationship with him:

_____

_____

_____

Describe your mother and your relationship with her:

_____

_____

_____

List your siblings and their ages:

_____

_____

_____

Describe your relationship with your siblings:

_____

_____

_____

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No

If yes, please describe when, where and by whom:

_____

_____

_____

Was this reported to the authorities? ( ) Yes ( ) No ( ) Don't know

Did you participate in treatment for this situation? ( ) Yes ( ) No ( ) Yes, but it wasn't helpful

Are you interested in addressing this issue in counseling currently? ( ) Yes ( ) No ( ) Unsure

Have you experienced or witnessed any of the following events in your life? ( ) Yes ( ) No

If yes, please check which ones you have experienced or witnessed:

- Natural disaster (i.e. flood, hurricane, tornado, earthquake) _____
- Fire or explosion _____
- Transportation accident (i.e. car accident, boat accident, train wreck, plane crash) _____
- Serious Accident at work, home, or during a recreational activity _____
- Exposure to toxic substance(s) (i.e. dangerous chemicals, radiation) _____
- Physical Assault (i.e. being attacked, hit, slapped, kicked, beaten up) _____
- Assaulted with a weapon (i.e. being shot, stabbed, threatened with a knife, gun, bomb) _____
- Sexual Assault (i.e. rape, attempted rape, made to perform any type of sexual act through force or threat of harm) _____
- Other unwanted or uncomfortable sexual experience _____
- Combat or exposure to a war-zone (in the military or as a civilian) _____
- Captivity (i.e. being kidnapped, abducted, held hostage, prisoner of war) _____
- Life-Threatening illness or injury _____
- Severe human suffering _____
- Sudden, violent death (i.e. homicide, suicide) _____
- Sudden, unexpected death of someone close to you _____
- Serious injury, harm, or death you caused to someone else _____
- Other: _____

Educational History

Highest Grade Completed _____ Where _____

Did you graduate high school? ( ) No ( ) Diploma ( ) GED

Did you attend college? ( ) Yes ( ) No ( ) Currently Enrolled

Where _____ Major _____

Have you attended graduate school? ( ) Yes ( ) No ( ) Currently Enrolled

Where _____ Focus of Study _____

Occupational History

Are you currently:

( ) Full-Time
( ) Part-Time
( ) Student
( ) Unemployed
( ) Disabled
( ) Retired

What is/was your occupation? _____

Where do/did you work? _____

Do/did you like your job? _____

Have you ever served in the military? ( ) Yes ( ) No

If so, what branch and when? _____

Honorably Discharged? ( ) Yes ( ) No Other type of Discharge _____

Relationship History & Current Family

Are you currently:

( ) Single
( ) Dating How Long? _____
( ) Separated How Long? _____
Hoping to get back together?
( ) Yes ( ) No ( ) Unsure
( ) Married How Long? _____
( ) Divorced How Long? _____
How many times? _____
( ) Widowed How Long? _____

How would you identify your sexual orientation?

( ) straight/heterosexual
( ) lesbian/gay/homosexual
( ) bisexual
( ) transsexual
( ) unsure/questioning
( ) other
( ) prefer not to answer

Describe your relationship with your significant other:

_____

_____

_____

Children:

#	Name	Age	Sex	#	Name	Age	Sex
1				4			
2				5			
3				6			

Describe your relationship with your children:

_____

_____

_____

Spiritual Life

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this time, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) more stressful ( ) neither

Social Relationships

Who would you consider your top 3 closest friends and why?

_____

_____

_____

How often do you go out with friends/co-workers socially?

( ) Never

( ) 1-2 times a month

( ) 1 time a week

( ) 2-3 times a week

Self-Care Strategies

What are your Strengths: _____

_____

What are you Weaknesses:

_____

_____

What hobbies or extra-curricular activities do you enjoy (i.e. hiking, reading, music, eating out, sports, etc.)?

_____

_____

_____

How often do you do these activities?

( ) Hardly Ever

( ) 1-2 times a month

( ) 3-4 times a month

( ) 2-3 times a week

( ) Daily

What self-care activities do you practice (i.e. massages, meditation, time alone, time with friends, exercise, etc.)?

_____

_____

_____

How often do you do these activities?

( ) Hardly Ever

( ) 1-2 times a month

( ) 3-4 times a month

( ) 2-3 times a week

( ) Daily

Any other information you think I should know?

_____

_____

_____

Thank You for taking the time to fill out this questionnaire and allowing me to get to know you better!