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Confidential Intake Questionnaire

Name: _____ Today's Date:_____

Date of Birth: _____ Age: ____ Gender:_____ Race/Ethnicity:_____

SS#:_____ Spiritual orientation/Religion:_____

Languages spoken/preferred communication method? (Please circle all that applies)

English ASL German Spanish Other:_____

❑ Cell Phone: _____ ❑ Home Phone: _____

❑ Email: _____

(☒ Please indicate your preferred method of contact)

Do I have your permission to leave a message at your preferred contact location? ❑ Yes ❑ No

Address: _____

City, State, Zip Code: _____

Emergency contact (Name & contact information): _____

_____

_____ Relationship: _____

Referral Source: _____

RELATIONSHIP STATUS: (please circle all that apply)

Single, not dating separated from partner or spouse living with a partner

Single, dating divorced widowed married domestic partnership

Who lives in your home with you? List names, ages, and relation to you. _____

_____

_____

_____

Do you have children who don't live with you? If so, list names, ages, and where and with whom they live: _____

_____

_____

MEDICAL HISTORY FORM

Your records are confidential. Your records will not be released to any party without your written consent.

Directions: Please answer the following questions to the best of your knowledge.

Name: _____

Medical Insurance: __ YES __ NO Carrier: _____

Carrier's Address: _____

_____ Carrier's Phone#: _____

Name of Insured: _____ Insured's Soc. Sec.#: _____

Do you have a doctor you usually see for medical services? If so, write his or her name and number below: _____

_____

_____

When was the last time you had a general medical checkup? _____

Are you pregnant? NA YES NO If YES, how many months? _____

Are you currently being treated for any health problems or recovering from any injury, surgery, etc.? If so, briefly describe here: _____

_____

Medications (List more on separate page if necessary)

Current Medications	For what condition? (What For?)	Dosage (How much?)	Frequency (How often?)	Started taking when?	Comments / Problems / Concerns

Past Medications / For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc.)

Medication Allergies? YES NO (please circle one)

If yes, what medication(s) _____

Do you have any allergies (Substance or Food Allergies)? YES NO (please circle one)

Is yes, what substance(s) _____

SOCIAL / SEXUAL RISK HISTORY

__ YES __ NO Do you smoke? If yes, how many cigarettes per day? _____

__ YES __ NO Do you use alcohol? If yes, how often, how much?_____

__ YES __ NO Do you or your partner(s) use drugs? If yes, how much, how often?

Ever injected drugs? (explain) _____

__ YES __ NO Are you currently in recovery from an alcohol or drug problem?

If YES, have you ever relapsed YES NO If YES, how many times ____

__ YES __ NO Have you ever had or would you like help now with an alcohol or drug problem?

__ YES __ NO Would you like to discuss problems to a rape or emotional/physical/sexual abuse?

__ YES __ NO Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

Estimate how many hours per day you spend online (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook: _____ YouTube: _____ Gaming: _____ Texting: _____ Browsing: _____

Work/School: _____ Other: _____

Do you feel your technology use is balanced and healthy or could it use improvement? Please explain:_____

_____

TRAUMA HISTORY

The events below may or may not have happened to you. Circle "YES" if that kind of thing has happened to you or circle "NO" if that kind of thing has not happened to you. **If you circle "YES" for any event**: put the number in the blank next to it to show how many times something like that happened.

			Number of times something like this happened to you
A. A really bad car, boat, train or airplane accident	No	Yes	_____
B. A really bad accident at work or home	No	Yes	_____
C. A hurricane, flood, earthquake, tornado, or fire	No	Yes	_____
D. Hit or kicked hard enough to injure – as a child	No	Yes	_____
E. Hit or kicked hard enough to injure – as an adult	No	Yes	_____
F. Forced or made to have sexual contact – as a child	No	Yes	_____
G. Forced or made to have sexual contact – as an adult	No	Yes	_____
H. Attack with a gun, knife, or weapon	No	Yes	_____
I. During military service – seeing something horrible or being badly scared	No	Yes	_____
J. Sudden death of close family or friend	No	Yes	_____
K. Seeing someone die suddenly or get badly hurt of killed	No	Yes	_____
L. Some other sudden event that made you feel very scared, helpless, or horrified.	No	Yes	_____
M. Sudden move or loss of home and possessions	No	Yes	_____
N. Sudden abandoned by spouse, partner, parent, or family	No	Yes	_____

Did any of these things really bother you emotionally? NO YES

If so, please list the letter from above for the type of event:_____

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to? YES / NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? YES / NO
3. Were constantly on guard, watchful, or easily startled? YES / NO
4. Felt numb or detached from others, activities, or your surroundings? YES / NO

FAMILY HISTORY: Please check if your family has a history of:

__ Diabetes (Sugar) __ High Blood Pressure __ Heart Attack, Heart Disease __ Cancer

__ Alzheimer's __ Tuberculosis __ Blood Clots or Stroke __ Mental Illness

__ Epilepsy/Seizure __ Family History Unknown

Any other major conditions? _____

_____

If you answered YES to any of the above, please explain: _____

_____

PERSONAL HISTORY:

Have you ever experienced a head injury, concussion, or been "knocked out" or unconscious? YES NO

Have you ever experienced an extremely high fever (over 103 degrees)? YES NO I don't know

Were there any complications before, during or just after your birth? YES NO I don't know

List any major illnesses or surgeries you have experienced: _____

_____

Are you currently seeing any other professional counselors or therapists for psychological services? Y N

Briefly describe why you are seeking psychological services: _____

_____

_____

_____

How long have you had these concerns or problems? _____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

Have you seen a psychiatrist, psychologist, or mental health counselor in the past? YES NO

If so, briefly describe: _____

_____

_____

_____

_____

FAMILY HISTORY:

Where were you born? _____

_____

Raised? _____

By biological parents? _____

_____

Brothers/Sisters? _____

_____

How would you describe your relationship with your family? Are you close to your parents & siblings?

_____

_____

_____

Was your family religious? If so, which religion did they belong to? If you attended church, how often?

_____

_____

_____

EDUCATION:

Where did you go to school? _____

_____

How far did you go in school? (Educational level) _____

How were your grades in school? _____

_____

How did you feel about going to school? (Positive/Negative Feelings) _____

_____

How did your teachers describe you? _____

_____

_____

If they were asked to say something negative? _____

_____

_____

How would you characterize yourself as being pretty social, or do you think you are more of a loner?

_____

_____

What group did you hang out with? _____

_____

What did you get in trouble for doing in school? _____

_____

Were you ever suspended or expelled from school? _____

_____

What were your successes and failures in school? _____

_____

_____

_____

What were your strengths and weaknesses in school? _____

_____

_____

EMPLOYMENT HISTORY:

Currently employed? YES NO If so, what is your present job? _____

Employer: _____

Business Address: _____

How long on that job? _____

What did you do before you worked (name present job)? _____

_____

What is the longest period of time you have held the same job?_____

_____

How would your bosses describe you? _____

_____

_____

If they were asked to say something negative? _____

_____

Are there any communications problems between you and your boss/co-workers? If so, please explain___

_____

Tell me about a job you were terminated from. _____

_____

_____

If you could have a job that you think suits your abilities best, not necessarily what you are doing now, what would that job be? _____

_____

RELATIONSHIP HISTORY

How many serious relationships have you had? _____

_____

_____

Of those, do you think you've ever been truly in love? If yes, how do you know?_____

_____

_____

_____

Have there been incidents of infidelity in your relationship?_____

_____

_____

SUBSTANCE ABUSE HISTORY

Has there ever been a period of time in your life when you've thought to yourself, " I think I might be drinking too much"? _____

_____

Have you ever used meth or crystal?_____

_____

Type	Date of Last Use	Amount of Last Use	Frequency and Amount of Use	Length of Time Using	Age of First Use

OFFENSE HISTORY

Have you ever been arrested? YES NO

If yes, how many times? _____

History of police involvement? (When and what for? Include juvenile involvement)_____

_____

_____

What stuff have you done that you haven't been caught for? _____

_____

Are you a good fighter? _____

_____

How many fights have you been in? _____

_____

Have you ever hurt anyone really bad? _____

_____

Just before you get into a fight (argument) with someone, do you think your heart rate increases, or does your body actually calm down? _____

_____

Are you court-ordered to attend therapy? YES NO

If YES, by whom/Social Worker/Probation Officer: _____
Contact Info/Phone:_____

RELATIONSHIP OFFENSE HISTORY

Have you ever experienced your parents or other adults fighting? YES NO
If so, what did they do? _____

_____

If yes, when was the first episode of aggression or physical abuse in your relationship? _____

_____

Have there been incidents of sexual aggression between you and your partner? _____

_____

Have you ever had a Temporary Restraining Order (TRO)/ Restraining Order (RO) against you? Do you now?_____

PSYCHIATRIC HISTORY

If you answered YES to having seen a therapist before: Did you get anything out of it, or do you think it was basically a waste of your time? _____

_____

Has there ever been a period of time when you've thought you might be down or blue or maybe even depressed? _____

_____

Do you think you've ever really hurt anyone emotionally? _____

_____

Have things ever gotten so bad for you that you've thought about killing yourself? _____

_____

_____

Have you ever threatened to kill yourself after a conflict with your partner?_____

_____

Have you ever tried to kill yourself? _____

_____

Have you ever been psychiatrically hospitalized? _____

_____

Do you ever feel like you won't be able to make it without your partner? _____

_____

When was the last time you cried? _____

_____

When we talk about self-esteem, kind of the way a person values him/her self, where would you place yourself on a scale of 1-10? _____

What didn't I ask that would be helpful to know about you? _____

_____

_____

_____

_____

What question do you have for me? _____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____