SHARA CARTER, M.A.ED, LPC, NCC

1801 ROBERT FULTON DRIVE UNIT 230 RESTON, VA 20191

INTAKE QUESTIONNAIRE

PERSONAL HISTORY

Client's NAME:_____ DATE:_____
Gender:_____ M_____ F Date of Birth:_____ Age:_____
Form completed by (if other than client)_____
ADDRESS:_____ CITY:_____STATE:_____ ZIP:_____
PHONE (Cell) :_____(Other phone)_____ (preferred phone?)_____
EMAIL:_____

Primary reason(s) for seeking services:

__Addictive Behaviors	__Coping	___Mental Confusion
__Alcohol/Drugs	___Depression	__Sexual Concerns
__ Anger Management	__Eating Disorder	__Sleeping Problems
__ Anxiety	__Fear/Phobias	
__ Career Counseling		

Other Mental Health Concerns:_____
What are your goals for therapy?_____
_____
_____

Please check behaviors and symptoms that occur to you more often than you would like them to:

__Aggression	__Dizziness	__Irritability	__Sleeping Problems
__Alcohol Dependence	__Drug Dependence	__Judgment Errors	__Speech Problems
__Anger	__Eating Disorder	__Loneliness	__Suicidal Thoughts
__Antisocial Behavior	__Elevated Mood	__Memory Impairment	__Thoughts Disorganized
__Anxiety	__Fatigue	__Mood Shifts	__Trembling
__Avoiding People	__Gambling	__Panic Attacks	__Worrying
__Chest Pain	__Hallucinations	__Phobias/Fears	__Work Issues
__Cyber Addiction	__Heart Palpitations	__Recurring Thoughts	__ OTHER: _____
__Depression	__High Blood Pressure	__Sexual Addiction	_____
__Disorientation	__Hopelessness	__Sexual Difficulties	_____
__Distractibility	__Impulsivity	__Sick Often	_____

Briefly discuss how the above symptoms impair your ability to function effectively:_____
_____
_____

Any additional information that would assist your therapist in understanding your concerns or problems:

Do you feel suicidal at this time? ____ YES ____ NO Homicidal? ____YES _____NO
If yes, please explain:_____
_____
_____

FAMILY INFORMATION

Marital Status (more than one may apply)

__Single __Annulment
__Legally Married __Unmarried, living together
__Widowed __Divorced
__Divorce in progress __Multiple marriages _____
__Separated __Length of time (any of the above)_____
Assessment of current relationship: _____Good ____Fair ____Poor ____None

Relationship	Name	Age	Living? Y/N	Living With you? Y/N
Mother				
Father				
Spouse				
Child				
Child				
Child				

Significant Relationships: (e.g., brother, sister, grandparents, other relatives. Please specify)

Relationship	Name	Age	Living? Y/N	Living with you? Y/N

DEVELOPMENT

Are there special, unusual or traumatic circumstances that affected your/ the client's development? ___Y ____N
If yes, please describe:_____
Has there been history of child abuse? _____ Y _____N
If yes, which type? _____Sexual _____Physical _____Verbal
If yes, the abuse was as a _____Victim _____Perpetrator
Other childhood issues: _____Neglect _____Inadequate nutrition _____Other (please specify)_____
_____

CULTURAL/EHNIC

To which cultural or ethnic group, if any, do you belong?_____
Are you experiencing any problems due to cultural or ethnic issues? _____Y _____N
If yes, please describe:_____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? _____Not _____Little _____Moderate _____Much
Are you affiliated with a spiritual or religious group? ____Y _____N Describe:_____
Were you raised within a spiritual or religious group? ____Y _____N Describe:_____
Would you like your spiritual/religious beliefs incorporated into counseling? _____Y _____N

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, reading, fishing, hunting, traveling, watching movies, writing, etc)

Activity	How Often Now	How Often in the Past

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SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

___Affectionate ____Follower ____Shy/Withdrawn
___Aggressive ____Friendly ____Submissive
___Avoidant ____Leader ____Other (Please specify)_____
___Fight/Argue Often ____Outgoing _____

Sexual Orientation:_____ Comments: _____
Sexual Dysfunctions? ____Y ____N Describe:_____
Any current or history of being a sexual perpetrator? ____Y ____N Describe:_____

EDUCATION

Fill in all that apply: Years of education: _____ Currently enrolled in school? ____Y ____N
____High School Graduate/GED
____Vocational: Number of Years:_____ Graduated: ___Y ____N Major:_____
____College: Number of Years: _____ Graduated: ___Y ____N Major:_____
____Graduate: Number of Years:_____ Graduated:____Y ____N Major:_____
Other Training/Schooling:_____

EMPLOYMENT

Begin with the most recent job, list job history:

Employer	Title/Job Type	Dates	Reason Left Job

Currently: _____FT _____PT _____Temp ____Laid-Off ____Disabled ____Retired ____SSI
____Student ____Other(Specify):_____

LEGAL

Are you involved in any active cases (traffic, civil, criminal)?____Y ____N
If yes, please describe:_____
Are you presently on probation or parole? ____Y ____N
If yes please describe: _____
Is there any past history of traffic, civil, or criminal legal issues? ____Y ____N
If yes please describe: _____

MEDICAL/PHYSICAL HEALTH

Current Prescribed Medications:

Medications	Dose	Dates	Purpose	Side Effects

CURRENT OVER-THE-COUNTER MEDICATIONS:

OTC Medications	Dose	Dates	Purpose	Side Effects

Are you allergic to any medications or drugs? _____Y _____N Describe:_____

Please check any/all that apply:

___AIDS/HIV
____Alcoholism
____Abdominal Pain
____Abortion
____Allergies
____Anemia
____Appendicitis
____Arthritis
____Asthma
____Bronchitis
____Bed-wetting
____Cancer
____Chest Pain
____Chronic Pain
____Colds/Coughs
____Constipation
____Chicken Pox
____Dental Problems
____Diabetes
____Diarrhea
____Dizziness
____Drug Abuse
____Epilepsy
____Ear Infections
____Eating Problems
____Fainting
____Fatigue
____Frequent Urination
____Headaches
____Heart Attack
____Hepatitis
____High Blood Pressure
____Kidney Problems
____Measles
____Mononucleosis
____Mumps
____Menstrual Pain
____Miscarriages
____Neurological Disorders
____Nausea
____Nose Bleeds
____Pneumonia
____Rheumatic Fever
____Sexually Transmitted Diseases
____Sleeping Disorders
____Sore Throat
____Scarlet Fever
____Sinusitis
____Smallpox
____Stroke
____Sexual Problems
____Tonsillitis
____Tuberculosis
____Toothache
____Thyroid Problems
____Vision Problems
____Vomitting
____Whooping Cough
____Other (describe)_____

_____

_____

List any current health concerns:_____

Please check if there have been any recent changes in the following:

____Sleep Patterns
____Physical Activity Level
____Eating Patterns
____General Disposition
____Behavior
____Weight
____Energy Level
____Nervousness/Tension

CHEMICAL USE HISTORY

PLEASE COMPLETE the CHART WITH THE FOLLOWING. Add any not listed as necessary: Alcohol, Barbiturates, Valium/Librium, Cocaine/Crack, Heroin/Opiates, Marijuana, PCP/LSD/Mescaline, Inhalants, Caffeine, Nicotine, OTHER

Substance	Method of Use	Frequency of Use	Age of first Use	Age of Last Use	Used in the Last 48 hours? Y/N	Used in the Last 30 Days? Y/N

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SUBSTANCE USE

Describe when and where you typically use substances:_____
_____

Describe any changes in your use patterns:_____
Describe how your use has affected your family of friends (include their perceptions of your use):
_____

Reasons for use:
_____Addicted ____Escape ____Socialization
____Build Confidence ____Self-Medication ____Taste
____Other (please specify):_____

How do you believe your substance abuse affects your life? _____
_____

Who or what has helped you in stopping or limiting your use? _____
_____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol? _____Y _____N
If yes, please describe:_____
Have you had adverse reactions or overdose on drugs or alcohol? Describe:_____
_____

Have drugs or alcohol created a problem for your job or school? _____Y _____N

COUNSELING/PRIOR TREATMENT HISTORY

Have you had previous treatment for any of the following?

Treatment	YES/NO	WHEN	WHERE	REACTION TO EXPERIENCE
Counseling/Psychiatric				
Suicidal Thoughts/Attempts				
Drug/Alcohol Treatment				
Hospitializations				
Self-Help Groups (AA, NA, Al-Anon)				

EATING AND WEIGHT

Current Weight _____ Highest Weight (excluding pregnancy) _____
Height:_____ Ideal Weight: _____ Lowest Adult Weight: _____
Eating Habits: _____Very Healthy _____Moderately Healthy _____Average _____Not Healthy

Are you satisfied with your eating patterns? ____Y ____N Do you ever eat in secret? ____Y ____N
Does your weight affect the way you feel about yourself? ____Y ____N
Have any members of your family suffered from an eating disorder? ____Y ____N
If yes, describe: _____
Do you currently suffer with or have you ever suffered with an eating disorder? ____Y ____N
If yes, describe: _____

Client Name: _____Signature:_____
Date:_____