INTAKE QUESTIONNAIRE

256 Seaboard Lane Suite E 102, Franklin, Tn. 37067

PERSONAL HISTORY/ IDENTIFICATION

(Identification) Client's NAME:_____
DATE:_____
Gender:_____ M_____ F Date of Birth:_____ Age:_____
Form completed by (if other than client)_____
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

(Presenting Problem/s) 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		

(History of Present Problem) How long have you been dealing with these issues? _____
_____

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

(Mental Status)
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:_____
_____
_____

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

(Risk Assessment) Do you feel suicidal at this time? ___ YES ___ NO Homicidal? ___YES _____NO
If yes, please explain:_____
_____
_____

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)				

***DEVELOPMENT/ TRAUMA HISTORY

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)_____
_____
Please briefly explain any past trauma history so your therapist can discuss this with you in session:
_____

FAMILY INFORMATION

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

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Parents presently married? _____Y _____N _____deceased
Other significant information regarding family history:_____

Family Medical and/or Psychiatric History:_____

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

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

MEDICAL/PHYSICAL HEALTH

Current Prescribed Medications:

Medications	Dose	Dates	Purpose	Side Effects

Current Over-the-counter medications:

OTC Medications	Dose	Dates	Purpose	Side Effects

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
____Diarrhea
_____Dizziness
____Drug Abuse
____Epilepsy
___Ear Infections
____Eating Problems
____Fainting
____Fatigue
____Headaches
____Heart Attack
___Hepatitis
____High Blood Pressure
____Mononucleosis
____Mumps
____Menstrual Pain
____Miscarriages
____Neurological Disorders
____Nausea
_____Pneumonia
_____Scarlet Fever
_____Sexual Problems
_____Sexually Transmitted Diseases
_____Sleeping Disorders
_____Smallpox
____Sore Throat
_____Stroke
_____Tonsillitis
_____Thyroid Problems
_____Vision Problems
____Vomitting
_____ Other (Please Describe)_____
_____

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List any current health concerns:_____

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

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

Please share any relevant PAST MEDICAL/HEALTH information that may be helpful to your therapist:_____
_____

SUBSTANCE 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**

Does/Has someone in your family present/past have/had a problem with drugs or alcohol? _____Y _____N

If yes, please describe:_____

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? _____
_____

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

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

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	_____

Please rate your social connectedness on a scale of 1-10 (1 being disconnected socially: "I don't have many friends", 10 being very connected socially: "I have many friends") _____

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

Sexual Orientation:_____ Comments: _____

Sexual Dysfunctions? ____Y ____N Describe:_____

Any current or history of being a sexual perpetrator? ____Y ____N Describe:_____

SPIRITAL/CULTURAL FACTORS

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

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EDUCATION/VOCATION HISTORY

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 HISTORY

Are you involved in any active caes (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: _____

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:_____