Vita
COUNSELING SERVICES

INTAKE QUESTIONNAIRE FOR NEW CLIENTS

Date: _____ Date of birth: _____Age:____

Name: _____ Email Address: _____

Home Address: _____ Preferred Phone: _____

_____ Occupation: _____

Marital Status: Single Married Separated Divorced

Remarried Engaged Widowed Cohabitating

What is the presenting issue that brings you to therapy?

_____

_____

How long have you been experiencing this issue?

_____

List any past psychiatric history (include past therapy experience and issues of self-harm or suicide attempts):

_____

_____

Do you have any history of trauma?

_____

_____

Circle any of the following abuses you have experienced in the past or are currently experiencing:

Physical Emotional Verbal Sexual Neglect

List any family history of psychiatric issues involving parents, siblings, grandparents, aunts/uncles (i.e. depression, anxiety, suicide attempts):

_____

_____

_____

_____

_____

List any current medical conditions & history:

_____

_____

List current medications:

_____

List any current or history of substance use:

Describe your family (who lives in your home with you, describe family relationships):

List hobbies and leisure activities:

Do you have a religious or spiritual affiliation? If so, please explain:

Who do you go to when you are experiencing difficulties?

Describe your developmental history (i.e. issues during pregnancy, childhood milestones met):

Describe your Educational/Occupational History (schools attended, highest degree achieved, past and current job/career):

Describe any legal issues/history:

Describe your strengths and weaknesses:

What do you hope to gain from therapy?

Is there anything else you would like me to know about you that would be helpful for therapy?

Symptoms – Please check any symptoms or experiences that you have had in the last month

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning
- ☐ Average hours of sleep per night _____
- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed mood
- ☐ Rapid mood changes
- ☐ Anxiety
- ☐ Frequent feelings of guilt
- ☐ Difficulty leaving your home
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe : - _____
- ☐ Outbursts of anger
- ☐ Worthlessness
- ☐ Sadness
- ☐ Fear
- ☐ Changes in eating/appetite: Eating more, Eating less (circle one)
- ☐ Binge eating
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise
- ☐ Difficulty catching your breath
- ☐ Unusual sweating
- ☐ Increased energy
- ☐ Tremor
- ☐ Frequent worry
- ☐ Racing thoughts
- ☐ Difficulty concentrating or thinking
- ☐ Flashbacks
- ☐ Self-mutilation/cutting
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else
- ☐ Feeling numb
- ☐ Irritability
- ☐ Panic attacks
- ☐ Avoiding people, places, activities, or specific things
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Feeling or acting like a different person
- ☐ Increase muscle tension
- ☐ Easily startled, feeling “jumpy”
- ☐ Decreased energy
- ☐ Dizziness
- ☐ Physical sensations other don’t have
- ☐ Intrusive memories
- ☐ Large gaps in memory
- ☐ Nightmares
- ☐ Difficulty problem solving
- ☐ Difficulty meeting role expectations
- ☐ Dependency on others
- ☐ Manipulation of others to fulfil your own desires
- ☐ Inappropriate expression of anger
- ☐ Ineffective communication
- ☐ Difficulty of inability to say “no” to others
- ☐ Sense of lack of control
- ☐ Abusive relationship
- ☐ Concerns about your sexuality
- ☐ Concerns about your gender identity
- ☐ Difficulty expressing emotions
- ☐ Decreased ability to handle stress
- ☐ Feeling “outside of yourself”, detached, observing what you are doing
- ☐ Feeling confused as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses or images
- ☐ Unusual visual experiences such as flashes of light, shadows
- ☐ Hear voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or radio is communicating with you.