LeAnn Gardner, LISW-CP
Counseling and Training

Intake Questionnaire

Name: _____Date of Birth: _____

Address: _____

Phone Number: _____

Ok to text? ☐ Yes ☐ No

Emergency Contact Name and Number: _____

_____

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for counseling?

Have you seen a mental health professional before? ☐ Yes ☐ No

Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number. _____

Who is your primary care physician? Please include type of MD, name and phone number. _____

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you have suicidal thoughts? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Do you have thoughts or urges to harm others? ☐ Yes ☐ No

Have you ever been hospitalized for a psychiatric issue? ☐ Yes ☐ No

Is there a history of mental illness in your family? ☐ Yes ☐ No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others. With family, etc…

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months:

- [ ] Increased appetite
- [ ] Decreased appetite
- [ ] Trouble concentrating
- [ ] Difficulty sleeping
- [ ] Excessive sleep
- [ ] Low motivation
- [ ] Isolation from others
- [ ] Fatigue/low energy
- [ ] Low self-esteem
- [ ] Depressed mood
- [ ] Tearful or crying spells
- [ ] Anxiety
- [ ] Fear
- [ ] Hopelessness
- [ ] Panic
- [ ] Other (Please explain):

Please check any of the following that apply:

- [ ] Headache
- [ ] High blood pressure
- [ ] Gastritis or esophagitis
- [ ] Hormone-related problems
- [ ] Head injury
- [ ] Angina or chest pain
- [ ] Irritable bowel
- [ ] Chronic pain
- [ ] Loss of consciousness
- [ ] Heart attack
- [ ] Bone or joint problems
- [ ] Seizures
- [ ] Kidney-related issues
- [ ] Chronic fatigue

- [ ] Dizziness
- [ ] Faintness
- [ ] Heart valve problems
- [ ] Urinary tract problems
- [ ] Fibromyalgia
- [ ] Numbness & tingling
- [ ] Shortness of breath
- [ ] Diabetes
- [ ] Hepatitis
- [ ] Asthma
- [ ] Arthritis
- [ ] Thyroid issues
- [ ] HIV/AIDS
- [ ] Cancer
- [ ] Other

Do you consider yourself a person of faith?

If so, please describe your faith in a few sentences.

Are you interested in me integrating this aspect of yourself into your work together? If yes, how?

What else would you like me to know?