

Intake Questionnaire

Today's Date: _____
 Your Name: _____
 Your Birthdate: _____ Age: _____
 Marital Status: Cohabiting Married Remarried
 (check all that Divorced Widowed
 apply)

How long have you *currently* been married or cohabiting?

How many children do you have? _____

How many of your children live with you? _____

Education: Some high school High school
 (highest Technical / Trades 2-year associate degree
 level) Some undergraduate college or university
 Undergraduate degree Some graduate level
 Graduate degree:

Income: \$0-30,000 \$31-60K \$61-90K
 (household annual) \$91-120K \$120-150K \$150K +

Current Occupation: _____

Years at Current Job: _____ Hrs per week: _____

Do you enjoy your work? A lot Moderately Very little

Career Goals: _____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over **the past two weeks**. The first six symptoms (a-f) relate to your relationship with your spouse or partner. (If you are single, circle "0").

(Circle a number)

a. Not talking to each other	0	1	2	3	4
b. Having bad arguments	0	1	2	3	4
c. Lack of trust between us	0	1	2	3	4
d. Feeling lonely in the relationship	0	1	2	3	4
e. Lack of affection and caring between us	0	1	2	3	4
f. Feeling unhappy about our relationship	0	1	2	3	4
g. Feeling sad, down or depressed	0	1	2	3	4
h. Avoiding certain people or places	0	1	2	3	4
i. Loss of interest in activities I normally enjoy	0	1	2	3	4
j. Low energy/feeling tired	0	1	2	3	4
k. Sleep problems (insomnia, not staying asleep, or early waking)	0	1	2	3	4
l. Eating too much or too little	0	1	2	3	4
m. Not able to think clearly	0	1	2	3	4
n. Feeling no pleasure or joy in life	0	1	2	3	4
o. Anxiety attacks	0	1	2	3	4
p. Worrying about things	0	1	2	3	4
q. Angry outbursts	0	1	2	3	4
r. Low self-esteem or low self-confidence	0	1	2	3	4
s. Feeling guilty	0	1	2	3	4
t. Feeling too stressed	0	1	2	3	4
u. Thoughts of suicide	0	1	2	3	4
v. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0	1	2	3	4
w. Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0	1	2	3	4
x. Not getting my work done	0	1	2	3	4
y. Feeling unhappy with my workplace	0	1	2	3	4

Symptoms Total: _____ / 100

Medical: Do you have any medical problems? Yes No

If yes, please list them: _____

Do you take any prescription **Medications**? Yes No

If yes, please list them:

Medication	Dose	Purpose	Since

Do you **Exercise**? Yes No If yes, what do you do?

Do you drink **alcohol**? Yes No

If yes, estimate how many times you typically drink in a month (i.e. how many drinking occasions): _____

Estimate how many standard drinks you typically drink per occasion (estimate your range if it varies): _____

Do you **smoke** tobacco? Yes No

If yes, please estimate quantity per day: _____

Do you drink **coffee/ tea**? Yes No

If yes, please estimate quantity per day: _____

Do you use any **illicit drugs**? Yes No

If yes, please specify: _____

If you drink alcohol or use illicit drugs, please answer the following questions:

- C. Have you ever thought you should **Cut** Yes No
down on your drinking/ drug use?
- A. Have people **Annoyed** you by Yes No
 criticizing your drinking/ drug use?
- G. Have you ever felt bad or **Guilty** about Yes No
 your drinking/ drug use?
- E. Have you ever had a drink / used drugs Yes No
 in the morning (**Eye opener**) to steady
 your nerves or to get rid of a hangover?

Are you concerned about the alcohol and/or drug use of anyone close to you? Yes No If yes, who?

Are you experiencing **abuse** in any of your **current** relationships?
 Yes No If yes: Physical Emotional Sexual
 By whom? _____

Have you ever experienced **abuse** in your **past** relationships?
 Yes No If yes: Physical Emotional Sexual
 By whom? _____

REASONS FOR SEEKING FOR COUNSELING

Check only those that apply. If you check more than one, please select your top three and rank them from highest to lowest in terms of the priority you place on resolving them (1=highest priority, 2=second highest, 3=third highest).

- | | |
|---|-------|
| (√) (Check all that apply) | Rank |
| <input type="checkbox"/> Depressed Mood | _____ |
| <input type="checkbox"/> Anxiety | _____ |
| <input type="checkbox"/> Anger Management | _____ |
| <input type="checkbox"/> Self-Esteem or Confidence | _____ |
| <input type="checkbox"/> Social Difficulties | _____ |
| <input type="checkbox"/> Stress Management | _____ |
| <input type="checkbox"/> Bereavement/ Loss | _____ |
| <input type="checkbox"/> Domestic Violence or Abuse (Current) | _____ |
| <input type="checkbox"/> Premarital Counselling | _____ |
| <input type="checkbox"/> Communication Problems/Relationship Conflict | _____ |
| <input type="checkbox"/> Sexual Intimacy Concerns | _____ |
| <input type="checkbox"/> Emotional or Sexual Infidelity/affairs | _____ |
| <input type="checkbox"/> Other Marital/Relationship Concerns | _____ |
| <input type="checkbox"/> Separation / Divorce / Relationship Break-Up | _____ |
| <input type="checkbox"/> Custody Concerns | _____ |
| <input type="checkbox"/> Parenting | _____ |
| <input type="checkbox"/> Parent-Adult Child Relations | _____ |
| <input type="checkbox"/> Blended Family Issues | _____ |
| <input type="checkbox"/> Family Conflict | _____ |
| <input type="checkbox"/> Work problems | _____ |
| <input type="checkbox"/> Education/ Career Concerns | _____ |
| <input type="checkbox"/> Financial Concerns | _____ |
| <input type="checkbox"/> Legal Concerns | _____ |
| <input type="checkbox"/> Medical Issues | _____ |
| <input type="checkbox"/> Substance Abuse (Alcohol/Drugs) | _____ |
| <input type="checkbox"/> Gambling Difficulties | _____ |
| <input type="checkbox"/> Other Addictions (i.e. Sex, Shopping) | _____ |
| <input type="checkbox"/> Eating Disorder | _____ |
| <input type="checkbox"/> Weight Management / Body Image | _____ |
| <input type="checkbox"/> Spiritual Problems | _____ |
| <input type="checkbox"/> Child – Behavioral Problems | _____ |
| <input type="checkbox"/> Child – Mood / Anxiety Problems | _____ |
| <input type="checkbox"/> Child – Academic Problems | _____ |
| <input type="checkbox"/> Child – Social/ Relational Problems | _____ |
| <input type="checkbox"/> Other _____ | _____ |

PREVIOUS TREATMENT

Have you participated in therapy or counseling in the past?
 Yes No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

Who do you turn to for social support (e.g. for encouragement, advice, friendship, etc.)?

Are there any organizations or agencies that you are currently receiving assistance or support from? Yes No If yes, please specify: _____

EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL / HEALTH DIFFICULTIES

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

- | | | |
|---|-------|-------|
| | Who? | When? |
| <input type="checkbox"/> Depression | _____ | _____ |
| <input type="checkbox"/> Bipolar Disorder | _____ | _____ |
| <input type="checkbox"/> Schizophrenia | _____ | _____ |
| <input type="checkbox"/> Other psychiatric disorders (i.e. psychosis, hallucinations) | _____ | _____ |
| <input type="checkbox"/> Suicide | _____ | _____ |
| <input type="checkbox"/> Physical / Sexual Abuse | _____ | _____ |
| <input type="checkbox"/> Substance Abuse (Alcohol/Drugs) | _____ | _____ |
| <input type="checkbox"/> Autism/Asperger's Syndrome | _____ | _____ |
| <input type="checkbox"/> Eating Disorder | _____ | _____ |
| <input type="checkbox"/> Chronic Illness (please specify illness) | _____ | _____ |
| <input type="checkbox"/> Accidental or Untimely Death | _____ | _____ |
| <input type="checkbox"/> ADHD or Learning Disorders | _____ | _____ |
| <input type="checkbox"/> Other | _____ | _____ |

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:

REFERRAL SOURCE

Please let us know how you learned about *-A Measure Of Health-* (Check all that apply):

- Internet search / website
- Word of mouth (family/friend)
- Another professional (physician, lawyer, etc.)
- Workshop or seminar
- I am a returning client
- My employer or health insurance provider
- Other _____

Thank-you very much for taking the time to fill out this questionnaire.