Centre for Life Solutions

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Intake Questionnaire

This questionnaire is to help me get an understanding of your experiences and situations, so that I help you receive the best possible treatment. Feel free to leave any questions blank which do not apply or which you prefer not to answer in this format. I will follow-up with you on many of these items.

Your Name: _____ Today's Date: _____

Please summarize your reason for seeking services at this time.

_____

_____

_____

_____

_____

When did you first begin to experience or notice the above concerns you're seeking help for?

_____

On a scale of 1-10, where 1 is the least amount of concern/distress you have ever experienced, and 10 is the absolute highest amount of concern/distress you have ever experienced, what number would you assign for your level of distress in the last week? _____

EDUCATION:

What is the highest school degree you have earned? _____ Are you in school now? _____

During school, did you receive any: ____ Special education? ___ Evaluation for a learning disability?
____ Tutoring? ___ Alternative schooling? ___ Disciplinary actions?

WORK/VOCATIONAL HISTORY

What is your current occupation?_____

Current Employer: _____

How long have you been employed in your present position? _____

Are you satisfied with your current job? _____Yes _____No

Since becoming an adult, how many different jobs have you held? _____

Have you had any periods of unemployment, which lasted four months or longer? __Yes __ No

If yes, please describe circumstances briefly: _____

Have you made any career changes? _____ Yes _____No

If yes, what was/were your previous occupation(s)? _____

Any major changes in your current work situation during the past year? ____Yes _____No

If yes, please describe: _____

MEDICAL HISTORY

Please list any medical conditions you have, the type of treatment you are receiving for each, and your treating physicians.

_____
_____
_____
_____
_____

Please list all medications you are currently taking, including dosages if you know them:

Medication	Dosage	Prescribed By

Please list all "over the counter" medications, sleep aids, vitamins, minerals, herbs and/or dietary supplements you are currently using:

Agent	**Dosage**	**Condition/Problem**

Have you ever had major surgery? _____ Yes _____ No

Describe:_____

Have you ever had a head injury which resulted in loss of consciousness or which may have been associated with a concussion or with problems in thinking, emotion or behavior? _____Yes _____ No

Have you ever had an extremely high fever (greater than 103 degrees F.)? _____Yes _____ No

Have you ever fainted or had a seizure? _____ Yes _____ No

Do you have any medication allergies or sensitivities? _____ Yes _____ No
If yes, please specify: _____

Do you have any food or seasonal allergies or sensitivities? _____ Yes _____ No
If yes, please specify: _____

Do you regularly engage in physical exercise? _____ Yes _____ No
If yes, please describe: _____

Please list any other medical conditions or concerns:

_____

_____

Date of last medical examination: _____

Name of Physician: _____ Contact #: _____

Would you like me to contact your doctor to coordinate your treatment with him/her: ___Yes ___No

PRIOR EXPERIENCE WITH PSYCHOLOGICAL TREATMENT

Have you been in counseling or psychotherapy previously? _____ Yes _____ No
If yes, please indicate when, and by whom: _____
_____

Was your prior counseling/psychotherapy helpful? _____ Yes _____ No

PREVIOUS PSYCHOLOGICAL/PSYCHIATRIC TREATMENT, CONT.

Have you ever taken medications for psychological/psychiatric reasons? _____ Yes ____ No
If yes, please indicate when, and for what conditions/problems:_____
_____

Have you ever been hospitalized for psychological/psychiatric reasons? ____ Yes ____ No

Has anyone in your family (parents, grandparents, siblings, children, other relatives) been diagnosed and/or treated for psychological/psychiatric condition(s)? ____ Yes ____ No
If yes, please describe _____
_____

CURRENT AND PAST USE OF ALCOHOL AND OTHER SUBSTANCES

If you currently drink alcohol, please describe the type of alcoholic beverages, the amounts, and the frequency: _____

_____

If you currently drink alcohol, how many days in the past year have you had 4, 5 or more drinks in one day? _____

If you have used, or currently use, any recreational drugs, please describe which ones and your pattern(s) of use: _____

_____

Have you ever tried to cut down on your use of alcohol or drugs? ____ Yes ____ No

Has anyone gotten angry at you because of your alcohol or drug use? ____ Yes ____ No

Have you ever felt guilty or worried about your use of alcohol or drugs? ____ Yes ____ No

Have you ever felt the need for an "eye-opener" in the morning? ____ Yes ____ No

Have you ever received outpatient alcohol and/or drug treatment or detoxification services? ____ Yes ____ No

Have you ever received inpatient alcohol and/or drug treatment or detoxification services? ____ Yes ____ No

Has anyone in your family had a problem with alcohol or drugs? ____ Yes ____ No

Please describe your past and current use of cigarettes and/or caffeine: _____

_____

_____

LEGAL ACTIONS/PROCEEDINGS

Please check all legal actions or proceedings you have been a part of:

____ Arrests/Assault ____ Arrests/Other* ____ DUI (how many?___)
____ Restraining/protective order(s) ____ Child Protective Services ____ Divorce/custody
____ Disability claim(s) ____ Other (describe)_____

PERSONAL INFORMATION

Place of Birth: _____ Where were you raised? _____

Have you experienced a loss (death, divorce, or significant situational loss) in the past 24 months? ____ Yes ____ No

Did you experience any losses as above during childhood or adolescence? ____ Yes ____ No
If yes, please indicate whom, and your age at the time of loss:_____

Have you relocated or changed jobs within the past 24 months? ____ Yes ____ No

How many siblings do you have, and what is your birth order among them?_____

Were you adopted or separated from your birth parents during childhood? ____Yes ____ No

Were/are your parents divorced? ____ Yes ____ No
If yes, please indicate your age at the time of their separation: _____

Please indicate your parents' current ages, or their ages at the time of their deaths:_____

Mother's occupation(s)/highest level of education:_____

Father's occupation(s)/highest level of education:_____

Has religion or spirituality played an important role in your life? ____ Yes ____ No

Has race, ethnicity or culture played an important role in your life? ____ Yes ____ No

Have you experienced physical, emotional or sexual trauma or abuse? ____ Yes ____ No
If yes, is this something we can talk about more in person? ____ Yes ____ No

Please check relationship status: _____Married? _____ Separated?
_____Divorced? _____ Widowed?
_____Committed Relationship?
Name of significant other: _____ Number of years together?_____

Please describe the quality of your relationship: ___ Excellent ___ Good
___ Needs Improvement ___ Poor
___ Possibly ending relationship
Name:_____ Date: _____

Do you have children/stepchildren? ____ Yes ____ No

Names & Ages _____

_____

What are some of the best (most positive) life experiences you have had?

_____

_____

What do you consider to be your strengths or talents?

_____

_____

What are some of the things for which you feel a sense of personal accomplishment/satisfaction?

_____

_____

How have you gotten through times of hardship or stress in the past?

_____

_____

What's going right in your life right now?

_____

_____

Who, if anyone, can you count on now when you need them? _____

Who, if anyone, really "gets" you and understands how you think or feel or do things?_____

What is it like when you are in a satisfying relationship (with peers, colleagues, friends, family members or loved ones)?_____

_____

Please use the space below to provide any additional information that you think would be important for me to know, including your goals for our work together.

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

_____

Signature