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. We 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?
- ☐ Tutoring?
- ☐ Evaluation for a learning disability?
- ☐ Alternative schooling?
- ☐ Disciplinary action?

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

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?) 0
☐ 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? If yes, please describe: ☐ 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 _____