

BASTYR CENTER FOR NATURAL HEALTH

-----Counseling-----

INTAKE QUESTIONNAIRE

Date: _____

NAME: _____ DOB _____

REFERRED BY: Self Family Friend Doctor Counselor Other

Name _____

May I contact the person who referred you and inform them that you scheduled an appointment with me? ___No ___Yes

If you are uncomfortable answering any questions that follow, you may leave them blank.

At our initial appointment we can review your answers in depth, clarify your goals, and determine together an appropriate course of action.

Gender:

___Man ___Woman ___Transgender ___Prefer not to disclose

Race (e.g., White, Black) _____

Ethnicity (e.g., Irish, Haitian) _____

Sexual Identity

___Heterosexual ___Bi-Sexual ___Gay / Lesbian ___Queer ___Questioning

Relationship Status (please check all that apply)

- Single, NOT romantically involved. Time since last romantic relationship: _____
- Single, romantically involved. How long have you been involved? _____
- Married./Domestic Partners. Number of years: _____
- Separated. How long? _____
- Divorced. Date of divorce: _____
- Widowed. Since? _____

What else would you like me to know about your lifestyle/relationship structure?

Languages spoken: _____

Religious affiliation/spirituality: _____

Involvement: None Some /irregular Active

Do you identify as having a disability? No Yes (please specify) _____

What else would you like me to know about you?

NAME: _____ DOB _____

Educational & Employment Information:

Please briefly describe your educational history:

Degree/Diploma	When? (e.g. 1990-1994)	Major/Focus of Study

Occupation: _____

Employer/University: _____

Employment: Full time Part time # of Hours/week _____

Approximate Annual Income _____

PRESENTING CONCERN:

What is the nature of the problem that brought you into counseling at this time?

Have you consulted any medical professionals about your present problem (e.g., doctors, healers)?

CURRENT CONCERNS:

Please mark items below that you are concerned about and make any notes on the page that may help me understand these concerns better. Feel free to indicate which of these items you would especially like to work on in counseling.

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect, cruelty to animals
- Adjusting to work/school
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Assertiveness
- Attention, concentration, distractibility
- Bipolar Disorder
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion

NAME: _____ DOB: _____

- Coming out
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters (e.g., charges, suits)
- Life Transition – Specify:
- Loneliness
- Couple's conflict, distance/coldness, infidelity/affairs, repartnership, different expectations, disappointments
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oppression (e.g., racism, sexism, heterosexism)
- Oversensitivity to rejection
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems

NAME: _____

DOB _____

- Self-centeredness
 - Self-esteem/acceptance
 - Self-neglect, poor self-care
 - Sexual issues, dysfunctions, conflicts, desire differences, other
 - Shyness, oversensitivity to criticism
 - Sleep problems—too much, too little, insomnia, nightmares
 - Smoking and tobacco use
 - Spiritual, religious, moral, ethical issues
 - Stress, relaxation, stress management, stress disorders, tension
 - Suspiciousness
 - Suicidal thoughts
 - Temper problems, self-control, low frustration tolerance
 - Thought disorganization and confusion
 - Transitions
 - Threats, violence
 - Weight and diet issues
 - Withdrawal, isolating
 - Work problems, employment, workaholism/overworking, dissatisfaction, ambition
- Any other concerns or issues:
- _____
- Which concern(s) on this list do you most want help with?
- _____

Please check (or highlight or bold if completing on computer) all the following symptoms that you have experienced:

= Recent (within the last month)

= Past (one month ago or longer)

- | | |
|--|--|
| <input type="checkbox"/> <input type="radio"/> change in appetite | <input type="checkbox"/> <input type="radio"/> feelings of restlessness |
| <input type="checkbox"/> <input type="radio"/> significant weight gain/loss | <input type="checkbox"/> <input type="radio"/> trembling or shaking |
| <input type="checkbox"/> <input type="radio"/> change in mood | <input type="checkbox"/> <input type="radio"/> accelerated heart rate |
| <input type="checkbox"/> <input type="radio"/> irritability | <input type="checkbox"/> <input type="radio"/> shortness of breath |
| <input type="checkbox"/> <input type="radio"/> feelings of worthlessness | <input type="checkbox"/> <input type="radio"/> sweating |
| <input type="checkbox"/> <input type="radio"/> changes in sleeping patterns | <input type="checkbox"/> <input type="radio"/> chest pain |
| <input type="checkbox"/> <input type="radio"/> loss of energy | <input type="checkbox"/> <input type="radio"/> feelings of choking |
| <input type="checkbox"/> <input type="radio"/> loss of interest in activities | <input type="checkbox"/> <input type="radio"/> nausea |
| <input type="checkbox"/> <input type="radio"/> loss or decrease in sexual interest | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of death |
| <input type="checkbox"/> <input type="radio"/> lost or irregular menstrual cycle | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of wanting to commit suicide |
| <input type="checkbox"/> <input type="radio"/> increase of energy | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of harming others |
| <input type="checkbox"/> <input type="radio"/> difficulty concentrating | <input type="checkbox"/> <input type="radio"/> cutting, punching or burning myself |
| <input type="checkbox"/> <input type="radio"/> nightmares | <input type="checkbox"/> <input type="radio"/> seeing things that others do not |
| <input type="checkbox"/> <input type="radio"/> substance abuse (alcohol or drugs) | <input type="checkbox"/> <input type="radio"/> hearing voices that others do not |
| <input type="checkbox"/> <input type="radio"/> problems with attention, motivation, memory | <input type="checkbox"/> <input type="radio"/> paranoid thoughts |
| <input type="checkbox"/> <input type="radio"/> recurrent and excessive anxiety or worry | <input type="checkbox"/> <input type="radio"/> compulsive behaviors (e.g., rituals, routines) |
| <input type="checkbox"/> <input type="radio"/> concussion(s)/head trauma | <input type="checkbox"/> <input type="radio"/> stroke |

NAME: _____ DOB _____

MENTAL HEALTH HISTORY:

Are you currently being seen by a mental health counselor? ___Yes ___No

Have you ever sought counseling for this or other concerns in the past? ___Yes ___No

With whom? _____ When? _____

What was the nature of the problem that led you to start counseling?

Have you ever received care in the hospital for a mental health concern? ___Yes ___No

Where? _____ When? _____

What was the nature of the problem that led you to receive care in the hospital?

In the past 12 months have you contemplated suicide? ___Yes ___No

If yes, please describe the situation(s) and trigger(s):

Have you ever intentionally harmed yourself in any way or attempted suicide? ___Yes ___No

If yes, please describe the situation(s) and trigger(s):

Do you currently take any medications for a mental health related concern? ___Yes ___No

Who prescribed your medication? _____

Please list all medications:

Do you currently use any herbs, supplements, or foods for a mental health related concern? ___Yes ___No

Please list:

NAME: _____ DOB _____

FAMILY-OF-ORIGIN HISTORY:

Please describe the following about the relationships in your family of origin:

Your parents' relationship with each other:

Your relationship with each parent and with other adults present:

Your parents' mental or emotional difficulties, physical health problems, and substance use:

Your relationship with your brothers and sisters (if any), in the past and present:

LIFESTYLE QUESTIONS:

Please describe what activities (if any) you currently engage in for physical exercise?

How often do you drink alcohol?

___ daily ___ weekly ___ monthly ___ never

When you drink, how much alcohol do you consume? _____

Have you ever felt you should cut down on your drinking? ___No ___Yes

Have people annoyed you by criticizing your drinking? ___No ___Yes

Have you ever felt bad or guilty about your drinking? ___No ___Yes

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? ___No ___Yes

Other Substance Use:

Please indicate frequency and quantity of use:

Caffeine:

Tobacco:

Marijuana:

Other:

PLEASE DESCRIBE YOUR GOALS FOR COUNSELING: