Silver Linings
Professional Counseling Services PLLC

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Intake Questionnaire

Please complete and bring to first session. Please be as honest as you can so your therapist can obtain a clear picture of your history in order to better your outcomes for treatment.

Name: _____ DOB: _____

Gender: ( ) Male ( ) Female

Reason for seeking treatment : Check all that apply

( ) Anxiety ( ) Depression ( ) Occupational ( ) Marital ( ) Relationships ( ) ADHD ( ) Infertility ( ) Adoption Issues/Education ( ) Trauma ( ) Greif ( ) Stress

Comments_____

List 3 goals that you hope to accomplish in counseling:

1_____

2._____

3._____

Other problems you might be experiencing:

Legal__ Financial___ School____ Victim of Abuse____

Others

_____

_____ Have you sought help for these problems before? Yes No

If yes, from whom/when?

_____

_____

_____

Have you been hospitalized for mental health issues? Yes No If yes, when and where?

_____

_____

_____

Do you know if you have ever been previously diagnosed with a mental disorder? What was it and when?

_____

_____

_____

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Have you:

Made a suicide attempt? ( ) Yes ( ) No

Injured yourself on purpose? ( ) Yes ( ) No

Overdosed on purpose or accident? ( ) Yes ( ) No

Have you had recent thoughts about?

Not wanting to live ( ) Yes ( ) No

Hurting yourself ( ) Yes ( ) No

Hurting someone else ( ) Yes ( ) No

Other thoughts worrying you

_____
_____
_____

Have you ever had the experience of seeing or hearing things that others are not experiencing

( ) Yes ( ) No

Current/past psychotropic medications

Please list medications and dosage

_____

_____

Health Concerns (Please list) If seeking infertility counseling, please list known reason for infertility (if applicable) and treatments pursued to this date: _____
_____
_____
_____

Childhood

Describe your childhood briefly:

_____
_____
_____

How would you rate your health during your childhood? ( ) Good ( ) Fair ( ) Poor

Explain:_____
_____
_____

Were you ever abused as a child? ( ) Yes ( ) No

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If so: ( ) Physical ( ) Sexual ( ) Emotional

Did anyone in your family suffer from mental illness or substance abuse problems when you were growing up? ( ) Yes ( ) No

Explain:

_____
_____

Other information about your childhood or family?_____
_____

Have you ever been married? ( ) Yes ( ) No How many times? _____ If currently married, how long? _____

If not married, are you in a relationship? ( ) Yes ( ) No

If in a relationship, how long? _____

Are you currently satisfied with your relationship (married or unmarried)? ( ) Yes ( ) No

If no, explain:

_____
_____

Do you have any kids? if so, how many and ages:_____
_____
_____

Education History

Highest grade completed? _____

Do you attend school now? ( ) Yes ( ) No If yes, what school?

_____

Socially, my school experience was? ( ) Easy ( ) Average ( ) Difficult

Academically, my school experience was? ( ) Easy ( ) Average ( ) Difficult

Work

Do you work? ( ) Yes ( ) No If not, why?

_____

Difficulties at work_____

How many hours per week? _____ How long at this job? _____ Type of job:

_____

Substance Abuse

Have you ever used alcohol or other drugs? ( ) Yes ( ) No

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Please list substances and at what age this started_____
_____
_____

Have you received outpatient/inpatient/residential treatment? ( ) Yes ( ) No

If yes, when? _____ Where? _____ How long?
_____

How many times? _____ Outcome?
_____

Legal history

Do you have a legal history? ( ) Yes ( ) No If yes, what charges?
_____
_____
_____

Other information

How well are you sleeping? ( ) Good ( ) Fair ( )Poor
How?_____

Have you ever witnessed an extremely stressful event? ( ) Yes ( ) No

If yes, explain:
_____
_____
_____

What are your

Strengths
_____
_____

Weaknesses
_____
_____

Mood Symptoms ; Check all that apply

( ) Depressed or irritable mood most of day, nearly every day. ( ) Psychomotor agitation/retardation( ) Diminished pleasure in activities. ( ) Fatigue or loss of energy. ( ) Decrease/increase in appetite.( ) Feelings of worthlessness/guilt ( ) Insomnia or hypersomnia nearly every day. ( ) Diminished ability to concentrate ( ) Extreme fluctuations in mood (high highs or low lows).

Ever had the complete opposite of symptoms for a period of time in your life?

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( ) Expansive thoughts, ( ) rapid/ pressured speech, ( ) engaging in outlandish shopping sprees, ( )impulsive behaviors, ( )promiscuity ( ) lack or need of sleep, ( ) Grandiosity

Suicidal ideation or attempt ( ) Yes ( ) No

How long ago? _____ months/years Number of attempts:
_____

Anxiety

( ) Unrealistic worry about future events. ( ) Unrealistic concern about past behavior. Marked self-consciousness. ( ) panic attacks ( )social fears ( ) phobias

( ) Unrealistic concern about competence. ( ) Excessive need for reassurance. ( ) Marked inability to relax.

How long? _____ months/years

Other

( ) Stereotyped mannerisms. ( ) Overreacts to touch. ( ) Odd postures. ( ) Compulsive rituals. ( ) Obsessive thoughts.

( ) Excessive reaction to noise. ( ) Fails to react to loud noises.

( ) Motor tics. ( ) Vocal tics. ( ) Learning problems? Please list_____

( ) Anger: If so, what is the result typically? _____
_____

Is there any other information that you think might be helpful for your therapist to know for the benefit of your treatment? Please explain in the space below