

Intake For Individual Counseling

This questionnaire will help me best understand your current difficulties as well as your past history. Please fill out this questionnaire to the best of your ability before your intake appointment and bring it with you. Read the questions carefully and answer them as fully as possible (use the reverse side of the paper if necessary). If there are questions that you don't understand, please mark them with a star (*) and we will review them with you at the intake appointment.

Personal Information

Date: _____

Name _____ Date of Birth: _____ Age _____

Spouse _____ Date of Birth: _____ Age _____

Parents & Siblings	Name(s)	Age(s)
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Children	Name(s)	Age(s)
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Home address: _____ Zip code _____

Telephone Numbers (Self): _____ (H) _____ (W) _____ (C)

Telephone Numbers (Spouse) _____ (H) _____ (W) _____ (C)

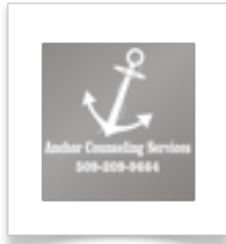
Email _____

Psychiatric Diagnoses (Past and Present)

Have you ever been suicidal? ___ Yes ___ No

If Yes please explain

Current Medications



What problems or questions have caused you to seek help at this time?

Are you employed? Yes No (if yes, specify how long job held and # hours/week)

Spouse employed? Yes No (if yes, specify how long job held and # hours/week)

Highest Level of Education Completed

Degrees/Diplomas

Any diagnosed learning difficulties? If so in what subjects? Yes No

Any Attention Deficit Disorder (with or without Hyperactivity?) Yes No

Please provide any information about each of your extended families that might help me understand your needs (medical, behavioral, psychological, educational, and emotional):

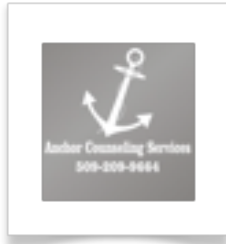
Is there any significant medical history for you or your spouse?

The following table is designed to assess your ability to relate to others.

self / spouse check all that apply.

<input type="checkbox"/> / <input type="checkbox"/>	Difficulty relating to others?
<input type="checkbox"/> / <input type="checkbox"/>	Verbally argue a lot with others?
<input type="checkbox"/> / <input type="checkbox"/>	Difficulty making friends?
<input type="checkbox"/> / <input type="checkbox"/>	Difficulty maintaining friendships?
<input type="checkbox"/> / <input type="checkbox"/>	Have at least one good friend?
<input type="checkbox"/> / <input type="checkbox"/>	Are you invited to friend's houses?
<input type="checkbox"/> / <input type="checkbox"/>	Like to host others at your house?
<input type="checkbox"/> / <input type="checkbox"/>	Have a small group of good friends?
<input type="checkbox"/> / <input type="checkbox"/>	Have difficulty with the non-verbal rules of social interaction (e.g. turn taking, how close to stand to others)

Y/N Do you like your spouse's friends?



Spiritual History

Spiritual upbringing. _____ Present affiliation _____

What time do you go to bed? _____ What time do you get up? _____

Is your sleep consistent? Y/N

Are you concerned that you don't get enough sleep and/or have poor sleep quality? Y/N

Get exercise ____ Yes ____ X's/week ____ No

Alcohol use

Self: _____ Never _____ Occasionally (1x/week or less) ____ 2-4x/week ____ Daily

Spouse: _____ Never _____ Occasionally (1x/week or less) ____ 2-4x/week ____ Daily

Drug use

Self: _____ Never _____ Occasionally (1x/week or less) ____ 2-4x/week ____ Daily

Spouse: _____ Never _____ Occasionally (1x/week or less) ____ 2-4x/week ____ Daily

List all drugs you have tried

Self

Spouse

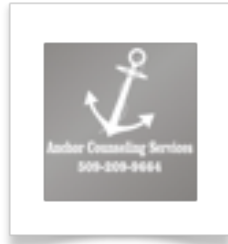
Work History: Please indicate below all major jobs/careers you have held. List the job title and amount of time spent working in this position.

Please describe any major family stressors that may have impacted you in the past or that may impact you now:

Are there any particularly traumatic or troubling events which have happened in your life which I should know about in order to understand you better? (please give details, include incidents you feel were traumatic even though they might not have been for someone else)

Have you ever witnessed violence inside or outside of the home? Yes ____ No ____

If yes, please explain



Have you ever had psychological counseling or therapy? ____ No ____ Yes
If Yes, Please list the names, addresses, and telephone numbers of any other professionals consulted. (This does not give me permission to contact them, and they will only be contacted with your written consent.)

What changes do you hope will result from seeking psychological services?

Is there any additional information or anything that you feel is pertinent to know that has not been covered in this questionnaire?

Who referred you to Anchor Counseling Services Spokane?