

INTAKE QUESTIONNAIRE

CLIENT INFORMATION:

Date:

Name:

Address:

Telephone Numbers (day)

(evening)

Can messages be left at day number?

Can messages be left at evening number?

Date of Birth:

Age:

Referred by:

Name

Address & Telephone

Family Physician:

Name

Address & Telephone

Emergency Contact Person:

Name

Address

Telephone (Day)

Telephone (Evening)

CURRENT DIFFICULTY:

Please indicate the reason that you are seeking services at this time. Briefly describe the nature of your difficulties and how long they have been present:

<p>Please check the severity of your difficulties:</p> <p><input type="checkbox"/>mildly upsetting</p> <p><input type="checkbox"/>moderately upsetting</p> <p><input type="checkbox"/>severe</p> <p><input type="checkbox"/>very severe</p> <p><input type="checkbox"/>extremely severe</p>	<p>How hopeful are you that these difficulties can get better?</p> <p><input type="checkbox"/>not hopeful</p> <p><input type="checkbox"/>somewhat hopeful</p> <p><input type="checkbox"/>pretty hopeful</p> <p><input type="checkbox"/>very hopeful</p>
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Have you consulted anyone about your difficulties? If so, please indicate name, title, address, and telephone number:

Have you ever received counselling/treatment/hospitalization for emotional difficulties?

- Yes
No

If yes, please describe when and reasons for previous treatment:

Have you ever received medication for emotional difficulties?

- Yes
No

If yes, please describe the name, how much, how frequently, and with what results:

Check off all that currently apply to you:

- | | |
|--|--|
| <input type="checkbox"/> work problems | <input type="checkbox"/> stress or burnout |
| <input type="checkbox"/> marital problems | <input type="checkbox"/> anger/frustration |
| <input type="checkbox"/> family problems | <input type="checkbox"/> easily agitated/annoyed |
| <input type="checkbox"/> relationship problems | <input type="checkbox"/> eating problems |
| <input type="checkbox"/> legal problems | <input type="checkbox"/> sleep problems |
| <input type="checkbox"/> financial problems | <input type="checkbox"/> low energy/fatigue |
| <input type="checkbox"/> school problems | <input type="checkbox"/> physical illness |
| <input type="checkbox"/> sexual problems | <input type="checkbox"/> concentration problems |
| <input type="checkbox"/> depression | <input type="checkbox"/> confusion |
| <input type="checkbox"/> low self-esteem | <input type="checkbox"/> memory problems |
| <input type="checkbox"/> guilt | <input type="checkbox"/> obsessions |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> compulsive behaviours |
| <input type="checkbox"/> loneliness | <input type="checkbox"/> alcohol/drug problems (spending, gambling) |
| <input type="checkbox"/> social isolation/withdrawal | <input type="checkbox"/> medication problems |
| <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> acting out or difficulties controlling impulses |
| <input type="checkbox"/> anxiety/panic | <input type="checkbox"/> racing thoughts |
| <input type="checkbox"/> fears/phobias | <input type="checkbox"/> unpleasant thoughts or dreams |
| <input type="checkbox"/> abuse issues | <input type="checkbox"/> suicide attempts |
| <input type="checkbox"/> traumatic experiences | <input type="checkbox"/> Other problems (please list): |
| <input type="checkbox"/> loss/grief issues | |
-

What major stresses are you are facing at this time?

What do you wish to accomplish from therapy?

What feelings do you wish to alter (e.g. increase or decrease)?

What behaviours or situations would you like to change?

PERSONAL HISTORY:

Please list any medical and/or health difficulties you are currently experiencing:

Are you taking any medication? If yes, please indicate the name, how much, how frequently, and with what results?

Please list any family history of illness:

Please list any family history of emotional difficulties:

Do you drink alcohol?

Yes

No

If yes, please indicate what kind of alcohol, how much, and how often (e.g. beer, 3 times/week):

Do you use any non-prescription or other substances?

Yes

No

If yes, please indicate what substance(s), how much, and how often:

Have you experienced any life events that were particularly distressing or traumatic for you?

Yes

No

If yes, please describe:

Please describe the nature of your friendships with others (e.g. number of friends, closeness of your relationships):

Please describe the extent to which:

- a) you feel comfortable trusting and confiding in others

- b) you feel supported and understood by others

How do you generally cope with stressful or upsetting circumstances (e.g. distract myself, talk to myself, seek support, think the worst of things, keep to myself, escape, drink, keep busy)?

What are current interests, activities, or hobbies you enjoy?

FAMILY INFORMATION:

Where were you born?

Where did you grow up?

Who did you live with during your childhood?

Please describe your childhood and the atmosphere in your home:

Please give a short description of your relationship with your mother, father or caregiver guardian:

Past:

Present:

If your mother is alive, what is her present age?

If your mother is deceased, what was the cause of death? What was your age at the time of her death?

If your father is alive, what is his present age?

If your father is deceased, what was the cause of death? What was your age at the time of his death?

How many brothers and sisters do you have? _____

Please list their gender and ages:

Please give a short description of your relationship with your brothers and sisters:

Past:

Present:

Please list your current relationship status:

- Single
- Married
- Committed Relationship
- Separated
- Divorced
- Widowed

If you are in a relationship, how many years have you been together?

Please describe your relationship including strengths and areas of concern:

Briefly describe any significant past relationships that continue to have either a positive or negative effect on you currently (e.g. abusive relationship, relationship with supportive grandparent, loss of loved one) :

Who currently lives with you?

How many children do you have?

Please list their gender and ages:

Please describe your relationship with your children including strengths and areas of concern:

EDUCATIONAL & OCCUPATIONAL HISTORY

Education (highest grade/level completed):

Did you experience any difficulties in school (e.g. behavioural, social, academic)?

- Yes
- No

If yes, please describe:

Are you currently employed?

- Yes
- No

If you are currently working, please describe nature of your occupation and how long you have been working there:

What do you find satisfying about your present occupation?

What ways are you dissatisfied by your present occupation?

SELF-DESCRIPTION

Please complete the following:

- a) I am a person who
- b) Ever since I was a child
- c) One of the things I feel most proud of is
- d) One of the things I regret is
- e) It's hard for me to admit
- f) I worry about
- g) Other people
- f) I wish _____

Please describe your strengths:

Please describe what bothers you about yourself:

OTHER:

Please add any information not brought up by this questionnaire that may aid your psychologist in understanding and helping you.