For Office Use Only
MRN#_____

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)**

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