CHANGES COUNSELING INTAKE QUESTIONNAIRE

General Information

Date: _____

Name: _____ Address: _____

City/State/Zip: _____

Phone (H): _____ Cell: _____ Work: _____

Email Address: _____

Sex: M ___ F ___ Age: _____ DOB: ___/___/_____ Social Security#: _____

Occupation: _____

Marital Status: Single __ Married ___ Divorced ___ Separated ___

Spouse Name: _____

Sex: M ___ F ___ Age: _____ DOB: ___/___/_____ Occupation: _____

Children? Yes ____ No ____

Name	Age	Sex	At Home?	Concerns?

Clinical and Crisis information

1. **Are you currently experiencing suicidal thoughts, feelings, or actions?**
   a. **If yes, please explain.**

2. **Have you ever been suicidal? Yes/No _____ Homicidal? Yes/No _____**

3. **State the concerns that brought you to counseling at this time?**

4. **State the history of these concerns (when did the problem begin; has it been constant or occasional?).**

5. **Have you received counseling for these or other concerns in the past?**

    a. **If yes, when and for how long?**

    b. **Counselors name: _____**

    c. **Reason for counseling at that time?**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Debit/Credit Card Information

Type of Card: Visa ____ MC ____ AMEX ____

Name on Card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

Medical Information

Please list any current medical problems:

_____
_____
_____
_____

List any medications you are currently taking, and the prescribed dosage:

_____
_____
_____
_____
_____

Please list all physicians whose care you are in:

Name: _____

Address: _____ **City/State:** _____ **Zip:** ____

Phone: _____

Name: _____

Address: _____ **City/State:** _____ **Zip:** ____

Phone: _____

Name: _____

Address: _____ **City/State:** _____ **Zip:** ____

Phone: _____

Self - Assessment

What is happening in your life which resulted in this appointment?

_____

_____

What would you like to see accomplished in therapy?

_____

_____

Chief Complaint *(Circle all that apply)*

Depression	**Low Energy**	**Low Self-Esteem**	**Poor Concentration**
Hopelessness	**Worthlessness**	**Guilt**	**Sleep Disturbance**
Appetite Disturbance	**Thoughts of hurting yourself**	**Thoughts of hurting someone**	**Isolation/social withdrawal**
Sadness/loss	**Stress**	**Anxiety/panic**	**Heart pounding/racing**
Chest pain	**Trembling/shaking**	**Sweating**	**Chills/hot flashes**
Tingling/numbness	**Fear of dying**	**Fear of going crazy**	**Nausea**
Phobias	**Obsessions/compulsive behaviors**	**Thoughts racing**	**Can't hold onto an idea**
Easily agitated/annoyed	**Excessive behaviors (spending, gambling)**	**Delusions/hallucinations**	**Not thinking clearly/confusion**
Feeling that you are not real	**Feeling that things around you are not real**	**Lose track of time**	**Unpleasant thoughts won't go away**
Anger/frustration	**Defies rules**	**Blames others**	**Argues**
Excessive use of prescription medications	**Blackouts**	**Physical abuse issues**	**Sexual abuse issues**
Spousal abuse issues			

Other: _____

Previous Outpatient therapy: Yes/No _____

What was accomplished? _____

Previous Hospitalization: Yes/No _____ If yes, when?: _____

Client Goal List

Please check any of the goals or concerns you would like to deal with in counseling:

CAREER/WORK:

Determine a career	**Difficulties at work**
Concern about alliances	**Cannot make decisions**
Other:	

Health Concerns:

Weight Change	**Vomiting and/or purging**
Problems with eating patterns	**Fast heart beat**
Difficulty sleeping	**Nightmares**
Lack of energy, tired all the time	**Dizziness**
Headaches	**Concerns over drugs/alcohol**
Other:	

Social and Family Relations:

Sexual concern	**Dealing with death or loss**
Shy with people	**Problems with parents/family**
Feeling lonely	**Problems with children**
Physical violence/battering issues	**Difficulty relating to others**
Other:	

Personal Concerns:

Suicidal thoughts	**Unhappy**
Can't concentrate/thoughts racing	**Sensitive; feelings easily hurt**
Depressed	**Worried; fearful**
Anxious; feeling panicky	**Feeling angry**
Feeling inferior; no self-confidence	**Feeling numb**
Feeling overwhelmed; hopeless	
Other:	

Personal Goals:

Develop assertiveness skills	**Accept personal limitations**
Develop coping skills	**Develop clearer personal identity**
Increase awareness of emotional responses	**Clarify personal goals/values**
Other:	