Clarity Counseling *Joan Forest LICSW*

Intake Questionnaire

NOTE: You may skip any question that you consider too personal or if it does not relate to your situation. Please write on the back of any page if an answer does not fit in the boxes.

TODAY'S DATE: _____

YOUR NAME: _____ DOB: _____ AGE: _____

PHYSICAL ADDRESS: _____

PO BOX: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____ HOME/MESS#: _____

_____

_____

PLEASE LIST FAMILY MEMBERS WHO LIVE WITH YOU:
(Ages, Gender, Relationship to Client: Biological/Adoptive/Step/Cohabitating Sibs, Etc.)

Name	Age	
Name	Age	
Name	Age	
Name	Age	
Name	Age	

Medical Insurance Plan if applicable:

_____ Insurance ID # _____

Group # _____

If other person is the primary insured put name, date of birth and relationship:

_____

LIST ANY CURRENT MEDICATIONS:

YOUR DOCTOR: PHONE# DATE LAST SEEN

PLEASE DESCRIBE THE HISTORY OF THE ISSUES OF CONCERN PRIOR TO COMING HERE FOR HELP:

HAS ANYTHING HELPED OR MADE IT WORSE (PLEASE DESCRIBE)

Have you been in counseling before? What dates and with whom? Was it helpful?

PAST EMOTIONAL HEALTH HISTORY: Please circle the words that describe your emotional status. You may write additional information on the back of any page.

DEPRESSED MOOD	Rarely	Sometimes	Often
IRRITABLE MOOD	Rarely	Sometimes	Often
EXTREME MOOD CHANGES	Rarely	Sometimes	Often: How often? _____days / weeks /months
APPETITE	Down	Ok	Too much
SLEEP	Little	Ok	Too much
ENERGY	Low	Ok	Too much
CONCENTRATION	Unable	Ok	Too focused
NIGHTMARES	None	Sometimes	Often
AGGRESSIVE FEELINGS	Rarely	Sometimes	Often : Describe_____
COMPULSIVITY	Rarely	Sometimes	Often
IMPULSIVITY	Rarely	Sometimes	Often
ANXIETY	Rarely	Sometimes	Often
EXCESSIVE WORRY	Never	Sometimes	Often
PANIC ATTACKS	None	Sometimes	Often
VOICES/VISUAL/TACTILE/OLFACTORY	None	Sometimes	Often
TRAUMA – DV +/-	None	Past	Recent : Describe_____
PHYSICAL/SEXUAL ABUSE	None	Past	Recent : Describe_____
RECENT DEATH / LOSS	No	Yes	Who?_____When?_____
SIGNIFICANT LIFE CHANGES	None	Past	Recent : describe_____
LEGAL PROBLEMS	No	Yes:Describe:_____	
PSYCHIATRIC HOSPITALIZATIONS	No	Yes:When? _____Why?_____	

SUICIDAL THOUGHTS	Never	Sometimes	Often Describe: _____
SUICIDE ATTEMPTS	No	Yes:Describe:_____	
SELF-HARM BEHAVIOR	No	Yes:Describe:_____	

HOSPITALIZATIONS: List all medical and psychiatric hospitalizations and/or serious illnesses & the date they occurred. Use back of this page if necessary.

LIST ANY MEDICATIONS TO WHCH YOU ARE ALLERGIC & Describe reaction

Name: _____

Signature: _____ **Date:** _____

Client Name _____ Date of Intake _____ Chart # _____

LEVEL I: _____ LEVEL II: _____ LEVEL III: _____

MENTAL STATUS:

APPEARANCE:

BEHAVIOR:

MOOD/AFFECT:

JUDGMENT/INSIGHT/IMPULSIVITY:

SPEECH/THOUGHT CONTENT:

MEMORY/ATTENTION/CONCENTRATION:

VEG SIGNS:

SLEEP: APPETITE: SEX DRIVE: S/I:H/I: PLAN?

DSM IV-TR DIAGNOSIS: CLINICAL FORMULATION:

AXIS I:

AXIS II:

AXIS III:

AXIS VI:

AXIS V: (GAF) (Current)

(Past Year):

Clinician's Name – Degree

Date