

Client ID _____

SAMPLE Employee Intake Questionnaire

Thank you for choosing Summit Counseling. This information will remain confidential and will assist your counselor in assessing your needs. Please bring the form to your first appointment. To protect your confidentiality do not mail, email or fax this completed form. If you have concerns about answering any of the questions, skip them and we will discuss these concerns at your first appointment.

CLIENT INFORMATION

Client Name _____ Date of Birth ____ / ____ / _____

Preferred Name or Nickname if Different _____

Address _____

City _____ Zip Code _____

Home Phone _____ Cell Phone _____

Relationship to the Employee: **Spouse** **Partner** **Daughter** **Son**

Where can we leave a confidential message? _____

Are you required by a court of law to receive counseling as part of a legal proceeding? Yes No

Have you ever served in the U.S Armed Forces? Yes No

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

Relationship to Client. _____

HEALTH AND MEDICAL

Primary Care Physician _____ Phone _____

Psychiatrist _____ Phone _____

Current Medical Conditions _____

Current Medications _____

SYMPTOM ASSESSMENT

Please describe your complaints and the primary reasons you have decided to see a counselor.

Please look at the following lists of experiences, feelings and behaviors. **These lists are optional.** They are designed to get you thinking about the problems you may be experiencing. If any of these seem to apply to you, indicate how often and for how long. Many items won't apply to you. Leave those lines blank.

I AM EXPERIENCING:	Rarely	Often	Always	Unsure	How Long?
Decreased interest in pleasurable activities					
Social isolation or loneliness					
Suicidal thoughts					
Changes in sleep habits					
Normal daily tasks require more effort					
Unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring distressing thoughts					
"Flashbacks" as if reliving some traumatic event					
A need to avoid people/places					
Nightmares					
Racing thoughts					
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Intrusive or strange thoughts					
Obsessive thoughts					
A lot of weight loss or gain					
Friends are asking 'what is wrong?'					
Problems with my speech					
Thoughts of "running away"					
Things seem like dream-like when I'm awake					
A need to lie about something					
An uncomfortable relationship					
My moods fluctuate up and down					
Laughing or crying for no obvious reason					
An inability to make decisions					

I AM FEELING:	Rarely	Often	Always	Unsure	How Long?
Bereavement or loss					
Sad, hopeless about future					
Guilt					
Low self-esteem					
Euphoric, energized and highly optimistic					
Fear of something or somebody					
Discomfort in social situations					
Angry, irritable or hostile					
Like laughing or crying at inappropriate times					
Shame					
Embarrassment					
Anger					
Hate					
Detached from my body, foggy					
Paranoid					
Worthless					
Disrespected					
Too heavy or too thin					
Jumpy					

I AM:	Rarely	Often	Always	Unsure	How long?
Engaging in compulsive or repetitive behaviors					
Acting without concern for consequences					
Physically harming myself					
Acting violently toward others					
Restricting my food consumption					
Bingeing and purging					
Binge eating					
Questioning my sexual orientation					
Hearing voices when alone					
Using alcohol					
Using illegal drugs					
Abusing prescription drugs					
Directing anger at others					
Having explosive fits of anger					
Keeping painful secrets					
Acting without concern for others					
Engaging in risky behaviors					
Having problems keeping a job					
Having problems with money or paying expenses					
Uncomfortable engaging in sexual activity					

PERSONAL AND FAMILY HISTORY

Have you ever been hospitalized for a psychiatric illness? Yes No

Does anyone in your family have a mental illness? Yes No

Has anyone in your family every attempted or committed suicide? Yes No

Does anyone in your family have a substance abuse problem? Yes No

Have you ever been arrested? Yes No

How well are you doing at your job?

<input type="checkbox"/>					
Not Working	Serious Problems	Moderate Problems	Mild Problems	No Problems	Extremely Well

How well are you doing in your marital / significant other relationship?

<input type="checkbox"/>					
Not Working	Serious Problems	Moderate Problems	Mild Problems	No Problems	Extremely Well

How well are you doing in your family relationships?

<input type="checkbox"/>					
Not Working	Serious Problems	Moderate Problems	Mild Problems	No Problems	Extremely Well

How well are you doing in relationships with people outside the home?

<input type="checkbox"/>					
Not Working	Serious Problems	Moderate Problems	Mild Problems	No Problems	Extremely Well

Please rate your current physical health.

<input type="checkbox"/>					
Very Poor	Serious Problems	Moderate Problems	Mild Problems	No Problems	Extremely Well

Please rate your overall happiness and well-being.

<input type="checkbox"/>					
Very Poor	Serious Problems	Moderate Problems	Mild Problems	No Problems	Extremely Well

Where did you learn about Summit Counseling? _____