CHANGES COUNSELING INTAKE QUESTIONNAIRE

General Information

Date: _____ Local Police number_____

Emergency Contact name and number: _____

Name: _____ Address: _____

City/State/Zip: _____

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

Email Address: _____

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

Occupation: _____

Marital Status: Single __ Married ___ Divorced ___ Separated ___

Spouse/Partner 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?**
   If yes, please explain.

   Have you ever been suicidal? Yes/No _____ Homicidal? Yes/No _____

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

Medical Information

Please list any current medical problems:

_____
_____
_____
_____

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

_____
_____
_____
_____

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			

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:	