**CREATE PATHWAYS COUNSELING, LLC**

**9990 Coconut Road, Bonita Springs, Florida 34135**

**(239) 390-1120**

[**info@createpathwayscounseling.com**](mailto:info@createpathwayscounseling.com)

**INTAKE QUESTIONNAIRE**

**Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you are in a relationship, please describe the nature of the relationship and months or years together.**

**Describe your current living situation. Do you live alone, with others, with family, etc.…?**

**What is your level of education? Highest grade/degree and type of degree.**

**What is your current occupation? What do you do? How long have you been doing it?**

**Please check ay of the following that apply:**

* Headache
* High blood pressure
* Gastritis or esophagitis
* Hormone related problems
* Head injury
* Angina or chest pain
* Irritable bowel
* Weakness
* Chronic pain
* Loss of consciousness
* Heart attack
* Bone or joint problems
* Seizures
* Kidney related issues
* Chronic fatigue
* Dizziness
* Faintness
* Heart valve problems
* Urinary tract problems
* Fibromyalgia
* Numbness & tingling
* Shortness of breath
* Diabetes
* Hepatitis
* Asthma
* Arthritis
* Thyroid issues
* HIV/AIDS
* Cancer
* Other

**Specify all medications and supplements you are presently taking and for what reason:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Purpose** | **Date Prescribed** |
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**If taking prescription medication, who is your prescribing doctor?**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is your primary care physician?**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What else would you like me to know about your physical health?**

**What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.**

**What are your coping skills that have helped you through times of pain, fear, grief or crisis?**

**What are your goals for counseling?**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you seen a mental health professional in the past 24 months?**

* Yes
* No

**If yes, what did you seek help for?**

**Did you benefit from the counseling?**

* Yes
* No

**Have you ever attempted suicide?**

* Yes
* No

**Do you have thoughts or urges to harm others?**

* Yes
* No

**Have you suffered from:**

* Psychological abuse
* Verbal abuse
* Emotional abuse
* Sexual abuse
* Physical abuse
* Domestic violence
* Child abuse
* Financial abuse

**If yes, please explain who, what, when, where, how:**

**Have you perpetrated or been accused of perpetrating:**

* Psychological abuse
* Verbal abuse
* Emotional abuse
* Sexual abuse
* Physical abuse
* Domestic violence
* Child abuse
* Financial abuse

**If yes, please explain who, what, when, where, how:**

**Please check any of the following you have experienced in the past six months:**

* Increased appetite
* Decreased appetite
* Physical abuse
* Distracted
* Hyperactive
* Impulsivity
* Boredom
* Lack of memory/confusion
* Seasonal mood changes
* Sadness
* Loss of pleasure/interest
* Lack of hope
* Thoughts of death
* Hurting
* Episodes of crying
* Loneliness
* Guilt/shame
* Lack of motivation
* Desire to be alone
* Panic attacks
* Fear of leaving the house
* Fear of being around others
* Antisocial behaviors
* Compulsive behavior
* Aggression/fights
* Harsh and frequent arguments
* Anger/irritability
* Retrospective scene
* Hearing voices
* Visual hallucinations
* Suspicious/paranoia
* Accelerated thoughts
* Excessive energy
* Humor changes
* Nightmares
* Bed wetting
* Internet addiction
* Problems with pornography
* Parenting issues
* Sexual problems
* Problems with where you live
* Problems with work/school
* Recurring or disturbing memories
* Difficulty sleeping
* Excessive sleep
* Low motivation
* Isolation from others
* Trouble concentrating
* Fatigue/low energy
* Low self-esteem
* Depressed mood
* Post-Traumatic Stress Disorder (PTSD)
* Tearful or crying spells
* Anxiety
* Fear
* Hopelessness
* Panic
* Substance use/addiction
* Other

**Was there a clear time when any of these symptoms worsened?**

* Yes
* No

**If yes, please explain:**

**Was there a clear time when any of these symptoms improved?**

* Yes
* No

**If yes, please explain:**

**Have you ever been hospitalized for a psychiatric issue?**

* Yes
* No

**Is there a history of mental illness in your family?**

* Yes
* No

**Have you ever been hospitalized for substance abuse issues?**

* Yes
* No

**Do you drink alcohol?**

* Yes
* No

**Do you use recreational drugs?**

* Yes
* No

**Treatment History (Include treatment/outpatient/inpatient in last 6 months):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Agency/Provider** | **Location** | **Length of Tx** | **Reason for Tx** |
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**In your LIFETIME, which of the following substances have you ever used:**

* Cocaine (coke, crack, etc.)
* Prescription stimulants (Ritalin, Adderall, etc.)
* Methamphetamine (speed, crystal, etc.)
* Inhalants (nitrous oxide, glue, paint, etc.)
* Sedatives (Valium, sleeping pills, Xanax, etc.)
* Hallucinogens (LSD, acid, mushrooms, Molly, etc.)
* Street opioids (heroin, opium, etc.)
* Prescription opioids (oxycodone, Methadone, etc.)
* Marijuana (pot, hash, etc.)

**In the past year, how often have you used the following:**

* Cocaine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Prescription stimulants \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Methamphetamine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Inhalants \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Sedatives \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hallucinogens \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Street opioids \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Prescription opioids \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Marijuana \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Alcohol (For men – 5+/day. For women – 4+/day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Tobacco products \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug of choice?**

**Date of last use?**

**Have you tried to quit before?**

* Yes
* No

**Longest period of abstinence?**

**How many children do you have?**

* 0
* 1
* 2
* 3 or more

**How has your substance use affected the relationship with your children?**

**Does anyone in your immediate family have a problem with substances?**

**Have concerned person(s) complained about your use of substances?**

**Do you have suicidal thoughts?**

* Yes
* No

**Have you experienced trauma in your life?**

* Yes
* No

**If yes, please explain who, what, when, where, how?**

**What do you normally do with your leisure time?**

**How many close friends do you have?**

* 0
* 1
* 2
* 3
* 4+

**Who do you call when you just need to talk to someone?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why?**

**What are your interests/hobbies?**

**Do you socialize with people who use drugs and/or alcohol?**

* Yes
* No

**What percent of leisure time do you spend drinking or using substances?**

**Do you identify with any specific culture or ethnicity?**

* Yes
* No

**If yes, what?**

**Do you feel your culture or ethnicity has offered you strengths or support?**

* Yes
* No

**If yes, how?**

**Do you feel your culture or ethnicity has presented you with stressors or barriers?**

* Yes
* No

**If yes, how?**

**Do you identify with any specific religion or spirituality?**

* Yes
* No

**If yes, what?**

**Do you feel your religion or spirituality has offered you strengths or support?**

* Yes
* No

**If yes, how?**

**Do you feel your religion or spirituality has presented you with stressors or barriers?**

* Yes
* No

**If yes, how?**

**Has there been, or do you desire any recent changes?**

* Yes
* No

**If yes, what and how?**

**Do you have any legal history?**

* Yes
* No

**If yes, please explain who, what, when, how, why:**

**What is your legal status now?**

**What stressors has your legal history had on your life?**

**What impact has your legal history had on your life?**

**Have you witnessed or experienced Domestic Violence?**

* Yes
* No

**If yes, how has domestic violence impacted your life?**

**Do you feel safe at home?**

* Yes
* No

**If no, do you have a safety plan?**

**If no, who is your support system?**

**Have you ever been in the military or served in a war?**

* Yes
* No

**If yes, how has your military experience impacted your life?**

**What is your current military status?**

**What else would you like me to know about your mental health?**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***I consent to sharing information provided here.***

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**