CREATE PATHWAYS COUNSELING, LLC
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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

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?

- o Yes
- o 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

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: _____