LANDMARK THERAPY LLC

Intake Questionnaire

Name: _____ Date: _____

What brings you to counseling at this time? Is there something specific, such as a particular event? Please be as detailed as possible.

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What are your goals for counseling?

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Who is your primary care physician? Please include name and phone number. _____

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Specify all medications and supplements you are presently taking and for what reason. _____

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

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

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

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

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

( ) Increased Appetite	( ) Decreased appetite	( ) Trouble Concentrating
( ) Difficulty Sleeping	( ) Excessive sleep	( ) Low Motivation
( ) Isolation from Others	( ) Fatigue/Low Energy	( ) Low self-esteem
( ) Depressed Mood	( ) Tearful or crying spells	( ) Anxiety
( ) Fear	( ) Hopelessness	( ) Panic Attacks
( ) Panic	( ) Relationship Issues	( ) Job Stress
( ) Hearing Voices	( ) Short Temper	( ) Loneliness

( ) Other (Please explain) _____

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Please check any of the following that apply.

( ) Headache	( ) High blood pressure	( ) Gastritis or esophagitis
( ) Head injury	( ) Angina/chest pain	( ) Irritable bowel
( ) Chronic pain	( ) Loss of consciousness	( ) Heart attack
( ) Bone/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	( ) Asthma
( ) Arthritis	( ) Thyroid issues	( ) HIV/AIDS
( ) Cancer	( ) Other	

Have you seen a mental health professional before? ( ) Yes ( ) No If yes, please specify dates, reason for counseling and your experience. _____

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Is there a history of mental illness in your family? ( ) Yes ( ) No If yes, please explain.

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Have you ever been hospitalized for a psychiatric issue? ( ) Yes ( ) No If yes, please describe, where, when, why? _____

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Do you drink alcohol? ( ) Yes ( ) No If yes, please describe type, amount, frequency. _____

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Do you use recreational drugs? ( ) Yes ( ) No If yes, please describe type, amount, frequency. _____

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In the past week, have you been having thoughts about killing yourself? ( ) Yes ( ) No If yes, please explain. _____

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Have you ever tried to kill yourself? ( ) Yes ( ) No If yes, please give details. _____

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Do you have thoughts or urges to harm others? ( ) Yes ( ) No If yes, please describe. _____

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Do you have a history of being abused emotionally, sexually, physically, or by neglect?

( ) Yes ( ) No If yes, please explain. _____

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Do you have any pending legal problems? ( ) Yes ( ) No If yes, please explain. _____

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Have you ever served in the military? ( ) Yes ( ) No If yes, which branch? _____

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Do you consider yourself to be spiritual or religious? ( ) Yes ( ) No If yes, please explain.

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What else would you like me to know? _____

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Client Signature: _____ Date: _____