Liberated Counseling, LLC

Intake Questionnaire

Please complete the following questionnaire before your first appointment. This helps me complete an intake assessment and get an overall picture of your current struggles and strengths. While some of these questions may seem like asking a lot of information, most of these questions are required by the norms of the counseling field in order to provide you the best possible service. Thanks!

Reason for seeking counseling:

Presenting Concerns (please check all that apply)

- ☐ Suicidal Thoughts
- ☐ Problems with Child / Children: _____
- ☐ Defiance / Oppositionality
- ☐ Anxiety / Worries
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty Being Alone
- ☐ Fatigue
- ☐ Guilt / Shame
- ☐ Hearing Voices / Hallucinations
- ☐ Memory / Concentration Problems
- ☐ Mood Swings
- ☐ Motivation Reduced / Absent
- ☐ Obsessive Thoughts
- ☐ Panic (or Anxiety) Attacks
- ☐ Physical Abuse
- ☐ Low Self-Esteem
- ☐ Weight Change
  - ☐ Increase ☐ Decrease
- ☐ Sexual Abuse
- ☐ Sleep Problems
- ☐ Trauma / PTSD
- ☐ Struggles Attaching / Having Relationships
- ☐ Grief and Loss
- ☐ Coming out / GLBTQ Concerns
- ☐ Unusual Thoughts
- ☐ Body Image Concerns
- ☐ Anger / Aggression / Violence
- ☐ Parent / Child Conflict
- ☐ Social Struggles
- ☐ Drug / Alcohol Use Concerns
- ☐ Addiction
- ☐ Eating Habits / Problems
- ☐ Lying Frequently
- ☐ Perfectionism
- ☐ Physically Abusive to Self
- ☐ Other: _____
- ☐ Other: _____
- ☐ Shy, Uneasy with Others
- ☐ Passive / Unassertive
- ☐ Unwanted Behavior / Habits
- ☐ Withdrawn
- ☐ Employment / School Issues
- ☐ Legal Problems
- ☐ Living Arrangements
- ☐ Money Management Issues
- ☐ Parenting Issues
- ☐ Relationship / Marital Issues
- ☐ Cutting / Self-Harm
- ☐ Existential / Spiritual Struggles
- ☐ Divorce / Separation
- ☐ Communication Struggles
- ☐ Individual Sexuality Concerns
- ☐ Personal Pleasure Concerns
- ☐ Couple Sexuality Concerns
- ☐ Relationship Pleasure Concern

Prior Behavioral Health Experiences

1. Outpatient Counseling (Dates, Clinic, Therapist, helpful?)

2. Intensive Treatment: IOP, Day or Residential Treatment, Hospitalization (Dates, Clinic, Therapist, helpful?)

Medical History (current and in the past)

Medical Conditions in the last year: _____

Chronic Illnesses: _____

Surgeries: _____

Head Injuries (diagnosed or otherwise): _____

Disabilities (physical or developmental): _____

Allergies: _____

Advanced Directives: _____

Medications (Name, Dose / Frequency, Start, End, Reason, Prescriber):

Substance Use History:

1. **Alcohol Use History** (Type, Quantity, Frequency, Periods of Heavier Use)
2. **Tobacco Use History** (Type, Quantity, Frequency, Periods of Heavier Use)
3. **Cannabis Use History** (Type, Quantity, Frequency, Periods of Heavier Use)
4. **Caffeine Use History** (Type, Quantity, Frequency, Periods of Heavier Use)
5. **Other Non-Prescribed Drug Use History** (Type, Quantity, Frequency, Periods of Heavier Use)

Vocational History:

1. Education History

Highest level of education to date: _____

Current School / Field of Study: _____

2. Employment History

Are you currently employed? YES NO Job Title: _____

Do you have any concerns about employment? YES NO : _____

3. Military Experience

Have you been in any branch of the military? YES NO Branch _____ Position _____

Reason for Discharge: _____

General Relationship Questions:

1. How long have you and your partner been together? _____
2. What initially attracted you to your partner? _____
3. What was the beginning of your relationship like and how long did this phase last?

   _____
4. What are some of the strengths in your relationship?

   _____

   _____
5. Describe your sexual relationship. What do you find most satisfying about it? What don't you like about it? How has your sexual relationship changed since you were first together? _____

   _____

   _____

   _____