Paul Haggan, Ph.D., LPC

# Intake Questionnaire

Name _____ Date _____

Gender: M___ F ___ Age ____ Date of Birth _____ Social Security Number:_____

Address _____ City _____ Zip_____

Telephone Number: Home_____ Cell: _____ Business _____

Education Completed (Grades, Courses, Degrees):_____

Religious Preference: (Denomination): _____

Employer: _____ Job Title: _____

Father's Occupation _____ Residence _____ His Age____ Age at death ____

Mother's Occupation _____ Residence _____ Her Age____ Age at death ____

**Relationship Information**

Single ____ Engaged ___ Married (Date) _____ Committed Relationship (Date)_____

Separated (Date)_____Widowed (Date)_____ Divorced (Date)_____ Previous Marriages__

Spouse or Partner's Name: _____ Age:_____ Occupation_____

Please rate your childhood: Very happy___ Happy__ Average__ Unhappy__ Very unhappy__

**Children**

Child's Name Age Comments: Residence, Custody, Guardianship etc.

1._____

2._____

3._____

4._____

Losses have you experienced within the past few years? (Deaths, divorce, moves, unemployment, etc.)

_____

_____

_____

**Siblings**

List all your brothers and sisters you have in order of their birth (step-siblings also):

| First Name | Age | Gender | Occupation | Marital Status | Living | Residence |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

List other persons who live or have lived in your home and their relationship to you?

_____

**Present Physical Health**

Very good __ Good __ Average __ Poor __ Medical exam with the past year? _____

If yes, indicate any significant findings:_____

What medication(s) are you currently taking? _____

Family Physician _____ Phone number: _____

**Personal Health History**

Please check all that apply to you?

| **Condition** | **Yes** | **Date** | **Condition** | **Yes** | **Date** | **Condition** | **Yes** | **Date** |
|---|---|---|---|---|---|---|---|---|
| Asthema | | | Cancer | | | Discouragement | | |
| Paralysis | | | Accident | | | Worries | | |
| Pneumonia | | | Sterility | | | Depression | | |
| Stroke | | | Surgery | | | Tension | | |
| Meningitis | | | Fainting spells | | | Irritability | | |
| Headaches | | | Convulsions | | | Alcoholism | | |
| High Blood Pressure | | | Low Blood Pressure | | | Sexual Dysfunction | | |
| Constipation | | | Miscarriage | | | Appetite Changes | | |
| Diarrhea | | | Menstrual Diff | | | Sleep Changes | | |
| Diabetes | | | Nerve Trouble | | | Substance Abuse | | |
| Thyroid Trouble | | | Heart Trouble | | | STD | | |
| Tumor | | | Anxiety | | | Other | | |

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**Self Assessment**

What is happening in your life that resulted in this appointment?

_____

What would you like to accomplish in counseling, consultation, and or therapy?

_____

**Symptom Checklist (Mark all that apply to you):**

_____ Anger/frustration
_____ Anxiety/Panic
_____ Depression
_____ Low self-esteem
_____ Low energy
_____ Poor concentration
_____ Hopelessness
_____ Worthlessness
_____ Guilt
_____ Sleep change (more/less)
_____ Appetite change (more/less)
_____ Thoughts of hurting yourself
_____ Thoughts of hurting someone
_____ Isolation/social withdrawal
_____ Sadness/loss
_____ Heart pounding/racing
_____ Chest pain
_____ Trembling/shaking
_____ Fear of dying
_____ Recent death of loved one
_____ Recent promotion/job change
_____ Recent departure of child
_____ Current/recent Divorce
_____ Recent separation
_____ Phobias
_____ Delusions/hallucinations
_____ Obsessions/compulsive behaviors
_____ Can't hold onto an idea
_____ Excessive behaviors (ie. spending)
_____ Not thinking clearly/confusion
_____ Feeling that you are not real
_____ Things around you aren't real
_____ Lose track of time
_____ Persistent unpleasant thoughts
_____ Easily agitated/annoyed
_____ Defying rules
_____ Blaming others
_____ Argumentative
_____ Excess use of alcohol or drugs
_____ Excess use of prescription meds
_____ Physical, emotional, sexual abuse
_____ Parenting Issues/Concerns
_____ Other problems or symptoms:

_____