Barbara Lauer, LCSW

Intake Questionnaire

Name

Date

PRESENTING PROBLEMS & CONCERNS

Summarize the challenges you are facing:

Please check all behaviors and symptoms you consider problematic:

- [ ] Distractibility
- [ ] Hyperactivity
- [ ] Impulsivity
- [ ] Boredom
- [ ] Poor memory/confusion
- [ ] Seasonal mood changes
- [ ] Sadness/depression
- [ ] Loss of pleasure/interest
- [ ] Hopelessness
- [ ] Thoughts of death
- [ ] Self-harm behaviors
- [ ] Crying spells
- [ ] Loneliness
- [ ] Low self worth
- [ ] Guilt/shame
- [ ] Fatigue
- [ ] Change in appetite
- [ ] Lack of motivation
- [ ] Withdrawal from people
- [ ] Anxiety/worry
- [ ] Panic attacks
- [ ] Fear away from home
- [ ] Social discomfort
- [ ] Obsessive thoughts
- [ ] Compulsive behavior
- [ ] Aggression/fights
- [ ] Frequent arguments
- [ ] Irritability/anger
- [ ] Homicidal thoughts
- [ ] Hearing voices
- [ ] Visual hallucinations
- [ ] Suspicion/paranoia
- [ ] Racing thoughts
- [ ] Excessive energy
- [ ] Wide mood swings
- [ ] Sleep problems
- [ ] Nightmares
- [ ] Eating problems
- [ ] Gambling problems
- [ ] Internet addiction
- [ ] Problems with pornography
- [ ] Parenting problems
- [ ] Sexual problems
- [ ] Relationship problems
- [ ] Work/school problems
- [ ] Alcohol/drug use
- [ ] Flashbacks
- [ ] Recurring disturbing memories
- [ ] Past traumatic experiences
- [ ] Feeling disconnected from the world
- [ ] Altered perceptions
- [ ] Emotional numbness
- [ ] Feeling disconnected from one's body

Other

Are your problems affecting any of the following?

- [ ] Handling everyday tasks
- [ ] Work/School
- [ ] Recreational activities
- [ ] Self concept
- [ ] Housing
- [ ] Sexual activity
- [ ] Relationships
- [ ] Legal matters
- [ ] Health
- [ ] Hygiene
- [ ] Finances

SAFETY

Have you ever had thoughts, made statements, or attempted to hurt yourself?

- [ ] Yes
- [ ] No

If yes, how many times and how long ago? Please describe:

Have you ever had thoughts, made statements, or attempted to hurt someone else?

- [ ] Yes
- [ ] No

If yes, please describe:

Have you recently been physically hurt or threatened by someone else?

☐ Yes ☐ No

If yes, please describe:

GAMBLING HISTORY

Have you gambled in the past 6 months?

☐ Yes ☐ No If yes, describe:

Have you ever felt the need to bet more and more money?

☐ Yes ☐ No If yes, describe:

Have you ever had to lie to people about how much you gambled?

☐ Yes ☐ No If yes, describe:

FAMILY & DEVELOPMENTAL HISTORY

Family members:

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/Partner			
Children			

Family mental health issues (note who):

☐ ADHD ☐ Sexually Abused ☐ Depression ☐ Manic Depression ☐ Suicide ☐ Anxiety ☐ Panic Attacks

☐ Obsessive-Compulsive ☐ Anger/Abusive ☐ Schizophrenia ☐ Eating Disorder ☐ Alcohol Abuse ☐ Drug Abuse ☐ Trauma

Parent status:

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

Mother remarried — number of times:

Father remarried — number of times:

Please check if you have experienced any of the following types of trauma or loss:

- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Parent substance abuse
- ☐ Teen pregnancy
- ☐ Neglect
- ☐ Violence in the home
- ☐ Crime victim
- ☐ Parent illness
- ☐ Placed a child for adoption
- ☐ Lived in a foster home
- ☐ Multiple family moves
- ☐ Homelessness
- ☐ Loss of a loved one
- ☐ Financial problems
- ☐ Parent mental illness
- ☐ Incarceration of a parent
- ☐ Teasing/bullying

PREVIOUS MENTAL HEALTH TREATMENT

Type of Treatment	Yes	No	When?	Provider/Program	Reason for Treatment
Outpatient Counseling	☐	☐			
Psychotropic Medication	☐	☐			
Psychiatric Hospitalization	☐	☐			
Drug/Alcohol Treatment	☐	☐			
Self-help/Support Groups	☐	☐			

SUBSTANCE USE HISTORY

	Current Use				Past Use			
Substance	Yes	No	Frequency	Amount	Yes	No	Frequency	Amount
Tobacco	☐	☐			☐	☐		
Caffeine	☐	☐			☐	☐		
Alcohol	☐	☐			☐	☐		
Marijuana	☐	☐			☐	☐		
Cocaine/crack	☐	☐			☐	☐		
Ecstasy	☐	☐			☐	☐		
Heroin	☐	☐			☐	☐		
Inhalants	☐	☐			☐	☐		
Methamphetamines	☐	☐			☐	☐		
Pain Killers	☐	☐			☐	☐		
PCP/LSD	☐	☐			☐	☐		
Steroids	☐	☐			☐	☐		
Tranquilizers	☐	☐			☐	☐		

Have you had withdrawal symptoms when trying to stop using any substances?

☐ Yes ☐ No If yes, please describe:

Have you ever had problems with work, relationships, health, or the law due to substance use?

☐ Yes ☐ No If yes, please describe:

MEDICAL INFORMATION

Have you experienced any of the following medical conditions during your lifetime?

- [ ] Allergies
- [ ] Chronic pain
- [ ] Dizziness/fainting
- [ ] High fevers
- [ ] Asthma
- [ ] Surgery
- [ ] Meningitis
- [ ] Diabetes
- [ ] Abortion
- [ ] Headaches
- [ ] Serious accident
- [ ] Seizures
- [ ] Hearing problems
- [ ] Sleep disorder
- [ ] Stomach aches
- [ ] Head injury
- [ ] Vision problems
- [ ] Miscarriage

Other

Please list any current health concerns

Current prescription medications

- [ ] None

Medication	Dosage	Date First Prescribed	Prescribed By

Current OTC medications (vitamins, herbal remedies, etc.)

ADDITIONAL INFORMATION

Highest level of school completed

Occupation

Spiritual/religious orientation

How would you describe your strengths?

Is there anything else you'd like me to know?