Resilience Counseling, LLC

5929 N May Ave, Suite 411 ♦ Oklahoma City, OK 73112 ♦ (405) 293-4483

INTAKE QUESTIONNAIRE

Client Name: _____ Date: _____

Preferred Name: _____

DOB: _____ Gender: _____ Gender Expression: _____

Address: _____City: _____ State: _____

Zip: _____ Phone: _____ May I leave a message on your voicemail? Y N

Occupation: _____ Work Phone: _____

Who referred you?_____

PRESENTING PROBLEM

Generally describe what has motivated you to seek counseling services. Concerns? Issue? Problem?

_____

_____

_____

TREATMENT HISTORY

Please include any prior inpatient or outpatient treatment history for mental health or substance abuse problems. Please include dates, previous therapist, and place of treatment if possible.

_____

_____

PERSONAL INFORMATION

Describe your living situation including number of persons in the household and their relationship to you.

_____

_____

Please describe any specific religious or cultural affiliations or practices that are significant to you.

_____

_____

Please describe any current or past addiction or substance abuse problems you have experienced. (i.e, alcohol, drug, sex, gambling, etc.)

Please describe any current or prior military service and dates of enlistment and deployment.

Please describe your current social support system (i.e., family members, friends, groups, community resources, etc.).

Please indicate the status of your current financial situation: Good Stable Fair Problematic

Highest Grade Completed: Less Than 9th grade 9th 10th 11th 12th High School Diploma

Some College Bachelor Degree Graduate Degree

FAMILY HISTORY

Please list current or past substance abuse in the family. Please include relationship of family member to the client and specific substances abused (i.e., alcohol, meth, etc.).

Please list current or past mental illness in the family. Please include relationship of the family member to the client and specific mental health problems or diagnoses, when possible.

Please list current or past domestic violence within the family.

LEGAL/CRIMINAL HISTORY

Please list any current or prior legal or criminal involvement. Include arrests, charges, and convictions as well as civil suits. For current legal or criminal involvement, please list key contacts such as the attorney, probation officer and contact information.

Have you ever physically assaulted another individual whether charged or not? Yes No
If yes, please provide the date(s) and circumstance(s).

Have you ever sexually perpetrated another individual whether charged or not? This includes rape, sexual assault and molestation. Yes No If yes, please provide the date(s) and circumstance(s).

_____

RELATIONSHIP/SEXUAL HISTORY

Sexual Orientation: Heterosexual Homosexual Bisexual Pansexual Polysexual Asexual _____

Relationship: Single Married Divorced Widowed Separated Cohabitating Other _____

Have you ever been pregnant? Yes No
If yes, please indicate the number of pregnancies, dates, and the outcomes (i.e., miscarriage, abortion, birth, etc.)

_____

_____

Have you ever been married or in a significant long-term relationship? Yes No If yes, please indicate the number of marriages/relationships, dates, and outcomes (i.e., widowed, divorced, currently married).

_____

_____

MEDICAL INFORMATION

Primary Care Physician: _____

Address: _____

Phone: _____

Psychiatrist (if applicable): _____

Address: _____

Phone: _____

Please list any current or prior medical problems.

_____

Please list all known food or drug allergies.

_____

_____

Emergency Contact: _____ Phone: _____

Please list all current and prior medications. (continue on back if needed)

Name of Medication	Dosage	Date(s) of Use	Side Effects/ Benefits	How effective was the medication?

TRAUMA

Are you a survivor of rape or other sexual assault? Yes No If yes, please provide the date(s) of the incident(s), and any information you are comfortable disclosing.

_____

_____

Are you a survivor of physical abuse, neglect (including childhood abuse and neglect), physical assault, or domestic violence? Yes No If yes, please indicate the date(s) of the incident(s) and any information you are comfortable disclosing.

_____

_____

Has there ever been any DHS involvement either in your childhood or with your children? Yes No
If yes, please indicate the date(s) and circumstance(s).

_____

_____

SYMPTOMS Please indicate any symptoms you are experiencing.

Sleep Disturbance Nightmares Sadness Irritability Thoughts of Suicide Change in Appetite Fatigue Guilt Loss of Interest in Activity Feelings of Worthlessness Loneliness Loss of Control Delusions Excessive Crying Paranoia Fear Excessive Worry Anxiety Anger Disorientation Euphoria Loss of Concentration Obsessive Thoughts Repetitive Behavior Racing Thoughts Risky Behavior Auditory Hallucinations Visual Hallucinations Drug Use Alcohol Use Self-Injury/Mutilation Tactile Hallucinations Physical Aggression Isolation/Withdrawal Criminal Activity Inducing Vomiting Excessive Exercise Family Conflict Conflict with Friends Loss of Interest in Sex Sexual Dysfunction Thoughts of Harming Others Excessive Talking Impulsivity

Other _____

Please indicate the frequency of the symptoms (i.e., 5x/day, 2x/month, etc.) you indicated above and describe any other symptoms.

On a scale of 1 to 7, Please indicate the severity of the problem(s) for which you are seeking services.

Very Mild	Mild	Somewhat Mild	Moderate	Somewhat Severe	Severe	Very Severe
1	2	3	4	5	6	7

OTHER