SPRING TO AUTUMN
FAMILY COUNSELING, INC.

INTAKE QUESTIONNAIRE

Client's name
Main reason for seeking therapy and how long has it been happening?
What are you hoping to get out of therapy?
Strengths and interests (skills, personality traits, intelligence, resiliency, hobbies)
Any safety concerns or issues within the past 6 months? (Suicide attempts or self harm)
Identifying information (ethnicity, religion, orientation, and other cultural factors)
History of counseling or psych treatment including names of previous therapist/psychiatrist
History of trauma, abuse, domestic violence or inter-agency involvement (social services)
Family members psychiatric history (Diagnosis, treatment, family member committed suicide)
Medical conditions and history (illnesses, accidents, or surgeries in the past)

1740 Plum Lane, Suite B ~ Redlands, CA ~ 92374
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Pregnancy history- any pregnancies, miscarriages, abortions, or other
Current medications and name of primary doctor
Substance use -drugs & alcohol (type of substance and amount of use)
Is there a history of substance use in your family?
Family composition – name and ages of children or other adults living in the home
Family, social or romantic relationships issues or support?
For minors/children - developmental history
Educational or occupational information (Any concerns about school or work)
Legal history
Within the past year- significant stressors (finances, births, deaths, moves, hospitalizations)?
How is your current level of functioning? (poor, fair, good, adequate, or excellent)

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In the past 6 months CLIENT has experienced:	Never	Sometimes	Often	Very Often	Explain/Intensity
Self care					
Stomach aches					
Headaches					
Many physical complaints					
Toileting Issues					
Defiance/Arguing/Verbal Aggression					
Frequent worry or tension					
Discomfort in social situations					
Inability to focus/difficult concentrating					
Impulsive behaviors					
Phobias: unusual fears about specific things					
Panic Attacks					
Recurring, distressing thoughts about a trauma					
Nightmares					
Decreased interest in pleasurable activities					
Social Isolation/ Loneliness					
Suicidal Thoughts					
Suicidal attempts					
Homicidal Thoughts or Attempts					
Cutting or Self Harm Behaviors					
Bereavement or Feelings of loss					
Changes in sleep (too much or not enough)					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					
Angry, irritable, hostile					
Euphoric, energized and highly optimistic					
Mood fluctuate: go up and down					
Memory problems or trouble concentrating					
Problems understanding what others tell them					

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In the past 6 months CLIENT has experienced:	Never	Sometimes	Often	Very Often	Explain/Intensity
Strange thoughts/ways of thinking					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with speech					
Risk Taking behaviors- no concern for consequences					
Compulsive or repetitive behaviors					
Been violent toward others/property					
Restriction of food consumption					
Binge Eating or purging					
A lot of weight loss or gain					
Uses illegal substances (drugs and alcohol)					
Gender identity issues					
Sexual Orientation Issues					
Social Relationship Issues					
Physical Health Issues					
General Feeling of Happiness					
Problems keeping a job					
Risk of homelessness					
Problems with healthcare					
Pregnancy Issues					
Relationship Issues					
Domestic Violence					
Sexual Functioning Issues					
Other symptoms not listed above:					

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