Wyatt Fisher, Psy.D., info@drwyattfisher.com, 303-596-6836

INTAKE QUESTIONNAIRE

Date:_____

NAME:_____ **SSN:**_____
DOB:_____ **AGE:**_____

ADDRESS:_____
_____
Street City State Zip

PHONE: Home (_____)_____ I**s it ok to leave a phone message?** (please circle) No Yes

Cell (_____)_____ **Is it ok to leave a phone message?** (please circle) No Yes

Please describe yourself as fully <u>as you feel comfortable</u>:

How much reluctance do you have about coming in for counseling today? Please circle one:

No reluctance at all Some reluctance Quite a bit of reluctance Strong reluctance

If more than one applies to you, please check all that apply:

Gender	*Relationship Status*	*Ethnicity/Race*
____Male ____Female	____Single ____Married or Partnered ____Separated ____Divorced ____Widowed ____Other_____	____ African-American ____ Arab American ____ Asian or ____Pacific Islander ____ Caucasian, European-American ____ Chicano, Latino, Hispanic ____ Native or ____ Alaskan Native ____Other_____

Religious affiliation/Spirituality:

Do you identify as having a disability? No Yes (please specify)

Are you a parent? No Yes (please list the age & gender of your children)

PRESENTING COMPLAINT:

What are you hoping to gain from counseling?

Please check all issues that currently concern you (indicate top three by writing the number 1, 2, and 3 next to the box):

☐ Academic/Work Problems ☐ Alcohol Use ☐ Anxiety ☐ Assertiveness ☐ Attention Deficit Disorder ☐ Bipolar (Manic -Depression) ☐ Clarification of Personal Values ☐ Depression ☐ Eating /Body Image ☐ Grief ☐ Improved Relationships with: ☐ Family ☐ Friends ☐ Partner ☐ Information/Education (specify): ☐ Making Decisions	☐ Racial/Ethnic/Cultural Issues ☐ Reducing Unhealthy Behavior ☐ Self-acceptance ☐ Self-care (hygiene, taking time for self) ☐ Self-understanding ☐ Sexual Issues ☐ Stress Management ☐ Substance Use ☐ Suicidal Thoughts ☐ Understanding My Impact on Others ☐ Working Through a Traumatic Event(s) ☐ Other (specify):

PLEASE DESCRIBE YOUR GOALS FOR COUNSELING: (please be as specific as possible)

HISTORY OF PRESENTING COMPLAINT:

When did you start having a problem with this?

How have you coped so far?

What strengths do you bring to this problem which will assist you in overcoming it?

Please check all the following symptoms that you have experienced:

☐ = **Current (within the last month)** ○ = **Past (one month ago or longer)**	
☐ ○ change in appetite	☐ ○ feelings of restlessness
☐ ○ significant weight gain/loss	☐ ○ trembling or shaking
☐ ○ change in mood	☐ ○ accelerated heart rate
☐ ○ irritability	☐ ○ shortness of breath
☐ ○ feelings of worthlessness	☐ ○ sweating
☐ ○ changes in sleeping patterns	☐ ○ chest pain
☐ ○ loss of energy	☐ ○ feelings of choking
☐ ○ loss of interest in activities	☐ ○ nausea
☐ ○ loss or decrease in sexual interest	☐ ○ recurrent thoughts of death
☐ ○ increase of energy	☐ ○ recurrent thoughts of wanting to commit suicide
☐ ○ difficulty concentrating	☐ ○ recurrent thoughts of harming others
☐ ○ nightmares	☐ ○ cutting or burning myself
☐ ○ substance abuse (alcohol or drugs)	☐ ○ seeing things that others do not
☐ ○ problems with attention, motivation, memory	☐ ○ hearing voices that others do not
☐ ○ recurrent and excessive anxiety or worry	☐ ○ paranoid thoughts

DESCRIBE YOUR CURRENT FUNCTIONING:

Describe how this problem has affected your academic and /or work performance:

Describe struggles you are having in your relationships (friendships / dating / partner)?

Describe your support systems (friends, family, spiritual or cultural groups, etc.): Are they in Boulder? No Yes

Describe your past and current levels of exercise or physical activity:

PERTINENT PERSONAL/FAMILY HISTORY: (Please fill in information about yourself and your family members)

	Biological?	*Age*	*Occupation*	*Mental Health Concerns*	*Physical Health Concerns*	*Medical Concerns*
You	n/a					
Parent	Y N					
Parent	Y N					
Brother/Sister	Y N					
Brother/Sister	Y N					
Brother/Sister	Y N					
Brother/Sister	Y N					
Others						

Are your parents married / separated / divorced / remarried? If divorced, how old were you at that time?

Describe your relationship with each parent:

Describe your relationship(s) with your sibling(s):

Have you lost any direct family members? No Yes – Please list:

Do family members (grandparents, aunts, uncles, etc.) have a history of mental health concerns (depression, anxiety, etc.)?

No Yes – Please list:

Is there a history of alcoholism in your extended family? No Yes – Please list:

MEDICAL HISTORY

Have you had…	*Current (within last month) Describe*	*Past (1 month ago or longer) Describe*
a head injury?	N Y	N Y
a seizure?	N Y	N Y
loss of consciousness?	N Y	N Y

significant injuries or illness?	N Y	N Y
medications prescribed?	N Y	N Y
known allergies to medications?	N Y	N Y
hospitalization for a medical condition?	N Y	N Y

PREVIOUS MENTAL HEALTH TREATMENT

Age	With Whom	How Long	Focus of Treatment	Helpful?	List Medications
				N Y	
				N Y	
				N Y	
				N Y	

Have you ever been hospitalized for mental health treatment? No Yes If yes, was it voluntary? No Yes

SUICIDAL/HOMICIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS

Have you ever had…	*Current (within last month) Describe*	*Past (1 month ago or longer) Describe*
thoughts of hurting yourself?	N Y	N Y
thoughts of suicide?	N Y	N Y
a plan for suicide?	N Y	N Y
an attempted suicide?	N Y	N Y
thoughts of hurting someone else?	N Y	N Y
an incident of actually hurting someone else?	N Y	N Y

TRAUMA HISTORY

Have you ever been a victim of a crime? No Yes

Physical (e.g., car accidents, assault, abuse, head trauma)

Emotional (e.g., victim of crime, abuse, loss or death of relative / friend)

Sexual (e.g., sexual harassment, sexual assault)

LEGAL HISTORY: Have you ever been arrested or convicted of a legal violation?

SUBSTANCE USE HISTORY: Please indicate your use of the following substances:

List	Current Use Frequency # of days of the week	Current Use Amount Per Day	Past Use Frequency # of days of the week	Past Use Amount of Use Per Day
Alcohol	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Other		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

WHAT ELSE DO YOU WANT YOUR COUNSELOR TO KNOW ABOUT YOU?