PATHFINDERS
COUNSELING AND CONSULTING

INTAKE QUESTIONNAIRE

The information in this packet is confidential and protected under the privacy act of 1974.

Date: _____

I. Demographics:

Name (First, Middle Initial, Last):_____

Name of parent/guardian (if under the age of 18 years old):_____

Gender: □ Male □ Female Birth Date: _____ Age: _____

Address (Street Number and Street Name):_____

City:_____ State:_____ Zip: _____

Phone number: (_____)_____ Type: □ Work □ Home □ Cell May we leave a message? □ Yes □ No

Alternate phone number: (_____)_____ Type: □ Work □ Home □ Cell May we leave a message? □ Yes □ No

Email Address: _____ May we email you? □ Yes □ No

Please note: Email correspondence is not considered to be a confidential means of communication.

How were you referred to us?_____

What issues/concerns brought you to therapy? _____

_____

_____

II. Race / Ethnic Ancestry:

□ Asian □ Black □ Caucasian / White □ Hispanic / Latino(a)
□ Native American / Alaskan □ Pacific Islander □ Other _____

III. Marital/Family History:

Check all that apply to you currently:
□ Never Married □ Separated □ Divorced □ Remarried □ Widowed
□ Dating □ Married □ Common Law □ Domestic partnership

How long have you been in a committed relationship (married, common law, domestic partnership)? _____

How is your relationship with your spouse / partner? _____

How many times have you been married? _____

Do you have any children? □ Yes □ No If yes, what are their ages and genders?_____

_____

How is your relationship with your children?_____

IV. Social History:

Who raised you? Indicate one or more of the following:
□ Biological parents □ Adoptive parents □ Relatives □ Step-parents □ Grandparents □ Others

Overall, how would you describe your childhood? Check all that apply:
□ Happy □ Uneventful □ Unhappy □ Hard to remember □ Frightening
□ Other: _____

Indicate if you experienced or witnessed any of the following types of abuse/assault at any time, including your childhood:

□ Physical □ Sexual □ Verbal □ Psychological / Emotional

V. Education:

What is your highest level of education?

□ Obtained GED □ High school graduate □ Partial college □ Associates college degree
□ College graduate □ Graduate degree in progress □ Graduate degree: _____

How would you describe your academic performance?

□ Excellent (A's and B's) □ Good (B's) □ High average (B's and C's) □ Average (C's) □ Poor (C's, D's, and F's)

Check all that applied to you during your schooling:

□ No problems □ Difficulty concentrating □ Difficulty with teachers/staff
□ Academic problems □ Behavioral problems □ Learning disabilities

VI. Legal History:

Have you ever been in jail/prison? □ Yes □ No

Are you currently on probation or parole, or awaiting a pending court case? □ Yes □ No

Prior and current charges/arrests (please list reasons and provide dates): _____

_____

VII. Employment History:

Are you currently employed? □ Yes □ No
If yes, describe your job: _____
Do you enjoy your work? □ Yes □ No
What is stressful about your current job? _____

Check all that applied during your employment. I had problems with:
□ No problems □ With supervisors □ Difficulty following rules
□ With coworkers □ With customers □ Difficulty controlling temper

VIII. Leisure/Social Functioning

Which of these do you enjoy doing in your free time?

□ Playing sports □ Reading □ Going to bars or clubs □ Playing video games □ Shopping
□ Motorcycles/Racing □ Talking with friends □ Exercising □ _____

Are you currently engaging in these leisure activities? □ Yes □ No

IX. Substance Use History

Have you ever excessively used alcohol? □ Yes □ No

On average, how many days per week do you currently use alcohol? (Please put N/A if you do not drink): _____

On average, how many drinks do you have at a time? _____

What is your drink of choice when you drink? _____

Have you ever used illicit / illegal drugs or misused prescription medications? □ Yes □ No

Do you currently use illicit / illegal drugs or misuse prescription medications? □ Yes □ No

What type(s) of drugs do you use? _____

What is the approximate date of your last use of illicit drugs? _____

Are you concerned about your current drinking or drug use? □ Yes □ No

Have you ever received substance abuse treatment (including treatment at a military base)? □ Yes □ No

If so, please list where you received treatment, and when this occurred: _____

_____

Do you use tobacco products? □ Yes □ No If yes, what type? _____

How much do you use (per day)? _____

Do you use caffeine products (e.g., soda, coffee, tea, caffeine, pills, chocolate? □ Yes □ No

If yes, what type? _____

How much do you drink/take per day? _____

X. Mental Health History:

Have you ever had outpatient treatment or therapy? □ Yes □ No

When were you treated, and by whom: _____

What was the diagnosis? _____

Have you ever been hospitalized in a psychiatric unit or psychiatric hospital? □ Yes □ No

When and where: _____

Have you ever experienced a head injury or traumatic brain injury? □ Yes □ No Describe: _____

_____

Are you currently taking psychiatric medications? □ Yes □ No

Name of Medication	Reason	Dose

Does anyone in your family have mental illness or an emotional difficulty? ☐ Yes ☐ No

Please specify: _____

Have you ever intentionally harmed yourself without suicidal intent (e.g. cutting, burning, etc.)? ☐ Yes ☐ No

If yes, when was the last time? _____

Are you feeling helpless or hopeless? ☐ Yes ☐ No

Do you have CURRENT thoughts of suicide or self-harm? ☐ Yes ☐ No

Do you have a specific plan or intent to hurt yourself currently? ☐ Yes ☐ No

Have you ever had suicidal thoughts or attempted suicide? ☐ Yes ☐ No

If yes, please list the date this occurred, and describe the circumstances: _____

_____

Do you have CURRENT thoughts about homicide or hurting someone else? ☐ Yes ☐ No

If yes, do you have a specific plan or intent to harm someone else? ☐ Yes ☐ No

XI. Medical History:

Current medical problems, surgeries, or illnesses and date of onset:

_____

_____

Do you have chronic pain? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

If yes, how many times per week: _____

If yes, what type of exercise do you do? _____

Do you follow any specific dietary practices (e.g., diet programs, gluten free, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any allergies (e.g., food, animals, seasonal, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

XII. Current Symptoms / Problems:

Check all that have applied to you in **the past 30 days**:

□ Sad mood	□ Risky behaviors	□ Abuse: Physical, Emotional, or Sexual
□ Loss of interest in activities	□ Gambling	□ Seeing people, animals, or things that others cannot see or say are not there
□ Feelings of guilt	□ Increased self-esteem	□ Hearing voices or noises that others cannot hear or say are not there
□ Low energy, tiredness	□ Decreased need for sleep / staying awake for several days	□ Feeling as if people are following you or watching you
□ Poor concentration	□ Unusual increase in energy / activity □ Trauma	□ Paranoid thoughts
□ Changes in appetite	□ Avoiding others	□ Problems in school or work
□ Weight gain (_____ lbs)	□ Repeated, unwanted thoughts / images	□ Problems with relationships
□ Weight loss (_____lbs)	□ Flashbacks: _____ per week / month	□ Pending divorce or separation
□ Difficulty falling asleep	□ Nightmares: _____ per week / month	□ Financial problems
□ Difficulty staying asleep	□ Memory problems	□ Extreme calorie restriction / counting
□ Unable to return to sleep	□ Panic or anxiety attacks	□ Self-induced vomiting
□ Decreased interest in sex	□ Anxiety in social or performance situations	□ Using laxatives to control weight
□ Increased interest in sex	□ Uncontrollable impulses	□ Weighing yourself daily
□ Grief/sense of loss	□ Repetitive behaviors / rituals	□ Troubles eating or swallowing
□ Excessive worry	□ Health problems	□ Fear of gaining weight
□ Rapid mood swings	□ Chronic pain	
□ Irritability		
□ Frequent anger outbursts		
□ Racing thoughts		

XIII. Personal Strengths:

Please check any of the following characteristics that you consider to be your strengths:

□ Empathy	□ Creativity	□ Curiosity	□ Open-mindedness
□ Integrity	□ Vitality	□ Love	□ Kindness
□ Leadership	□ Forgiveness / mercy	□ Humility / modesty	□ Prudence
□ Gratitude	□ Hope	□ Humor	□ Spirituality
□ Love of learning	□ Perspective / wisdom	□ Bravery	□ Persistence
□ Social intelligence	□ Socially responsible / teamwork	□ Fairness	
□ Self-regulation / self-control	□ Appreciation of excellence / beauty		

XIV. Support / Spirituality:

Do you have any spirituality concerns? □ Yes □ No

Please check any of the following you consider to be a source of support:

□ Spouse / Partner	□ Nuclear / Immediate Family	□ Extended Family	□ Close Friend
□ Group of Friends	□ Church / Synagogue / Mosque / Temple	□ 12-Step Program	□ Service System

If you have never served in the military, SKIP to page 8.
Current and prior military, continue to the next section.

XV. Military Service

Indicate the component and service branch that apply to you:

□ Active Duty □ National Guard □ Reserves
□ Air Force □ Army □ Coast Guard □ Marines □ Navy

Enlistment / commission date: _____ Discharge date: _____

Job / Duty Title: _____ Duties: _____

Current Rank: _____ Highest Rank: _____ TIS: _____

Check all that apply to you with regard to your military service:

□ No problems □ Physical outbursts □ Negative counseling(s)
□ Problems with Chain of Command □ Verbal disagreements □ Administrative action
□ Difficulty following rules □ Difficulty controlling temper □ Problems with others in unit

Did you receive any of the following? [ ] Court Martial [ ] Article 15's [ ] UCMJ [ ] Other: _____

If so, please provide the date of disciplinary action, and briefly describe the circumstances:

_____

_____

Were you ever sexually assaulted while serving in the military? □ Yes □ No

Have you deployed to a combat zone? □ Yes □ No

Please provide date(s) of deployment(s), duration of tour (e.g., 12 months), and location below:

Start Date	End Date	Duration	Location

Did you receive incoming fire from small arms, mortars, or bombs? □ Yes □ No

At any point in your military service, did you experience anything that continues to cause nightmares / intrusive thoughts? □ Yes □ No

If yes, **BRIEFLY** describe the disturbing thing(s) that happened to you during your military service that still bothers you:

_____

_____

_____

During the event(s):

- Were you physically injured? □ Yes □ No
- Was someone else physically injured? □ Yes □ No
- Did you think your life was in danger? □ Yes □ No
- Did you think that someone else's life was in danger? □ Yes □ No

How did you respond emotionally DURING or AFTER the disturbing event(s)? Please circle all that apply.

Horror	Excited	Terror	Confused	Helpless	Shame
Fear	Sadness	Grief	Guilt	Other feelings: _____	

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ADULT PSYCHIATRY ADDENDUM

The information in this packet is confidential and protected under the Privacy Act of 1974.

INSTRUCTIONS: This portion of the packet is to be completed by adult patients beginning psychiatric care.

I. PATIENT INFORMATION:

Name (First, Middle Initial, Last): _____

Gender: □ Male □ Female Birth Date: _____ Age: _____

II. MEDICAL HISTORY

Were there serious problems/complications during your birth or delivery? □ Yes □ No

Did you walk, talk, and learn to toilet about the same age as other children? □ Yes □ No

Did your biological mother use any of the following when pregnant with you?

Vitamins	Yes	No	
Supplements	Yes	No	Which ones? Dose?
Alcohol	Yes	No	How much/often
Drugs	Yes	No	Which drugs/how often
Cigarettes/tobacco	Yes	No	How much/often

Surgeries

Date(s)	Reason	Outcome

Emergency Room Visits

Date(s)	Reason	Outcome

Please indicate if any of the following have ever applied to you:

	Past	Now	Never
Heart disease			
Arrhythmias			
ADHD			
Autism			
Diabetes			
Speech/Language problems			
Separation/Anxiety disorders			
Mental retardation			

	Past	Now	Never
High blood pressure			
High cholesterol			
Held back at school			
Trouble reading/writing			
Cerebral palsy			
Neurological issues			
Developmental delays			
Thyroid problems			

Please list ALL medications / supplements you have taken in the **LAST YEAR** for any medical or health condition:

Name of Medication	Reason	Dose	Still Taking?

Medication allergies (Please list all medication allergies)

Indicate if you ever experienced the following with a check mark and date:

	Date		Date
❒ Lead ingestion/exposure	_____	❒ Head injuries	_____
❒ Date of last hearing test:	_____	❒ Loss of consciousness	_____
❒ Ear infections (number)	_____	❒ Seizures	_____
❒ Loud Snoring	_____	❒ Heart Disease	_____
❒ Heart murmur	_____		

III. FAMILY MEDICAL HISTORY

Please indicate if any of the following have occurred in your family:

	Mother	Father	Child	Sister	Brother	Maternal Grandparent	Paternal Grandparent	Aunt	Uncle
Heart disease									
Arrhythmias									
Sudden death									
High blood pressure									
High cholesterol									
ADHD									
Autism									
Diabetes									
Anger problems									
Hearing voices									
Attempted suicide									
Completed suicide									
Obsessions or compulsions									
Hyperactivity									
Held back at school									
Trouble reading/writing									
Cerebral palsy									
Schizophrenia									
Alcohol abuse									
Drug abuse									
Speech/Language problems									
Separation/Anxiety disorders									
Mental retardation									
Behavior problems									
Depression									
Neurological issues									
Developmental delays									
Thyroid problems									

Thank you for completing this questionnaire

Please complete any additional measures or turn in your paperwork to the front desk if complete.