Intake Questionnaire For New Patients

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide will be confidential as required by state and federal law.

Date: _________________ Social Security Number: ________________________

Name:_________________________________ Date of Birth: ____________________ Age: _______

Home Address: ______________________________________ City/State/Zip Code: ____________________

Home Phone: _____________________ Cellular/Alternative Phone _____________________

Marital Status: single married separate divorced
Remarried engaged widowed cohabitating

If applicable, please complete the following:

Partner's Name: ______________________ Partner's Age: _____

Partner's Occupation: _________________________________

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adult and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

____

____

____

____

How long has this been going on? ____

What made you come in at this time?

____

____

____

What do you hope to gain from counseling?

____

____

____

If you had difficulties in the past, what have you done to cope? Was it helpful?

____

____

____

Symptoms:

Please check any symptoms or experiences that you have had in the last month

☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Difficulty getting out of bed
☐ Not feeling rested in the morning
☐ Average hours of sleep per night: ___________

☐ Persistent loss of interest in previously enjoyed activities
☐ Withdrawing from other people
☐ Spending increased time alone
☐ Depressed mood
☐ Feeling Numb
☐ Rapid mood changes
☐ Irritability
☐ Anxiety
☐ Panic attacks
☐ Frequent feelings of guilt
☐ Avoiding people, places, activities or specific things
☐ Difficulty leaving your home
☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: ______________________________
Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands) Describe: ______________
☐ Outburst of anger

☐ Worthlessness
☐ Hopelessness
☐ Eating more
☐ Eating less
☐ Voluntary vomiting
☐ Use of laxatives
☐ Excessive exercise to avoid weight gain
☐ Binge eating
☐ Are you trying to lose weight? __________

☐ Weight gain: ______ lbs.
☐ Weight loss: _______ lbs.
☐ Difficulty catching your breath
☐ increase muscle tension
☐ Unusual sweating
☐ easily started feeling "jumpy"
☐ Increased energy
☐ Decreased energy
☐ Tremor
☐ Dizziness
☐ Frequent worry
☐ Physical sensations others don't have
☐ Racing thoughts
☐ Intrusive memories
☐ Difficulty concentrating or thinking
☐ Large gaps in memory
☐ Flashbacks
☐ Nightmares
☐ Thoughts about harming or killing yourself
☐ Thoughts about harming or killing someone else

☐ Feeling as if you were outside yourself, detached, observing what you ae doing
☐ Feeling puzzled as to what is real and unreal
☐ Persistent, repetitive, intrusive thoughts, impulses, or images
☐ Unusual visual experiences such as flashes of light, shadows
☐Hear voices when no one else is present
☐ Feelings that your thoughts are controlled or placed in your mind
☐ Feeling that the television or the radio is communicating with you
☐ Difficulty problem solving
☐ Difficulty meeting role expectations
☐ Dependency on others
☐ Manipulation of others to fulfill your own desires
☐ Inappropriate expression of anger
☐ Self-mutilation/cutting
☐ Difficulty or inability to say "no" to others
☐ Ineffective communication
☐ Sense of lack of control
☐ Decreased ability to handle stress
☐ Abusive relationship
☐ Difficulty expressing emotions
☐ Concerns about your sexuality

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:
____
____
____
____

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

☐ No ☐ Yes If so:

Name of therapist: ____________________

Reason for seeking help: ____________________ Dates of Treatment: ____________________

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Name of therapist: ____________________

Reason for seeking help: ____________________ Dates of Treatment: ____________________

Are you **CCURENTLY** taking P**SYCHIATRIC** medication: ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**	**Has it been helpful?**

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**

Have you been on P**SYCHIATRIC** medication in the past? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**	**Has it been helpful?**

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If YES, please list:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ No ☐ Yes If YES, please list:

____

____

____

____

MEDICAL HISTORY

Are you CURRENTLY under treatment for nay medical conditions? ☐ No ☐ Yes If YES, please list:

____

____

____

____

List any PRIOR illnesses, operations and accidents

____

____

____

FAMILY HISTORY

Father: Age: ______ ☐ Living ☐ Deceased Cause of death: __________________

Occupation: _____________________________ Health: _______________________________

Frequently of contact with him: __________________ Are you/Have you been close to her? ___________

Mother: Age: ______ ☐ Living ☐ Deceased Cause of death: __________________

Occupation: _____________________________ Health: _______________________________

Frequently of contact with him: __________________ Are you/Have you been close to her? ___________

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?	
				NO	YES
				NO	YES
				NO	YES
				NO	YES

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problem							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Past Marital History

Have you bee married previously? _______________ If Yes, please describe

When? ____________________ How long? _______________________

When? ____________________ How long? _______________________

Education

Highest grade level completed: ________________

Degree obtained, if applicable: ________________

Did you have any disciplinary problems in school? _________

If yes, please explain: ____

Were you considered hyperactive/ADHD in School? ________

If yes, were/are you on any medication? _________

If yes, were/are you on any medication? _________

If so, which medication? ________________________

What kinds of grades did you get in school? _________________________________

Have you served in the military? ____________

If yes, please describe briefly: ____

____

What type of discharge (separation) did you get? ____

Employment

Are you currently employed? ____________

If yes, employer's name: _____________________________________

What type of work do you do? ________________________________

Employment History (most recent first)

Type of Job	**Dates**	**Reason for Leaving**

Have you been arrested? ______________

If yes, please describe: ____

Do you have a religious affiliation? _____________

If yes, please describe: ______________________________________

What kind of social activities do you participate in? ____

Who do you turn to for help with your problems? ____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe:

____

____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? If yes, age of your first use: ________

How much do you drink? ________________________________

How often do you drink? ________________________________

Have you ever passed out from drinking? __________________ How often? ____________________

Have you ever blacked out from drinking? _________________ How often? ____________________

Have you ever had the “shakes” __________________________ How often? ____________________

Have you ever felt you should cut down on your drinking/drug use? _____________________

Have people annoyed you by criticizing your drinking/drug use? _________________________

Have you ever felt back or guilty about your drinking/drug use? _________________________

Have you ever drank/used drugs in the morning to steady your nerves or relive a hangover? ________________

Do you use tobacco? ________________

If yes, how often? _______________________

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approximately use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

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Qualifications

I obtained a Master of Education with a concentration in Clinical Mental Health Counseling from Lamar University and a Bachelor of Art in Sociology with a minor in Psychology from Texas A&M University. I am a Licensed Professional Counselor. My formal education has prepared me to counsel individuals, groups, couples, families, adolescents, and children.

I am a member in good standing of the American Counseling Association, Association for Humanistic Counseling, Texas Counseling Association, Texas Association for Humanistic Education & Development, Houston Counseling Association, and Chi Sigma Iota.

Theory of Counseling

There are many counseling approaches and techniques which may be utilized at any given time to meet a client's specific needs. My counseling approach is based on a combination of Solution-Focused Brief Therapy, Reality/Choice Therapy, and Cognitive Behavioral Therapy. Solution-Focused Brief Therapy is based on the optimistic assumption that people are competent and able to construct solutions that can enhance their lives. You will have the opportunity to describe your problems, set goals for yourself, and offer feedback. The goal of Reality/Choice Therapy is to help people become more effective in meeting their needs; to enable clients to get reconnected with the people they have chosen to put into their quality worlds and teach clients choice theory. Cognitive Behavioral Therapy involves a learning process where clients acquire and practice new skills; learn new ways of thinking, and more effective ways of coping with problems. I will ask that you complete homework assignments, as I believe that the work we do in session will be most effective if implemented in your life outside of therapy.

Nature of counseling

- Sessions are held one time per week for 50 minutes.
- The counseling relationship is a professional relationship rather than a social one. You will best be served if our sessions concentrate solely on your concerns. Gifts are discouraged and will not be accepted.
- Our contact will be limited to the counseling sessions you arrange with me at the Houston Center for Training and Supervision office.
- Please note that it is not possible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.
- If I see you in public, I will protect your confidentiality by not approaching you first, nor will I discuss your case with you in public.
- If you should need to contact me, I may be contacted by telephone at **281-940-8042** or email at **andreagriggstherapy@gmail.com**. Contact via social media (Facebook, LinkedIn, Twitter, etc.) is strictly prohibited.

Client Rights

- It is your right at any time to inquire about the process and procedures being used during our counseling relationship. You have the right to refuse or request changes to any of my suggestions. If at any time you are not satisfied with my services for any reason, you can inform me or the board of licensed professional counselors.
- Once you have begun counseling with me, there is no obligation to continue. You have the right to discontinue at any time, though I ask that you participate in a termination session. Should you desire a referral to another therapist, I will provide you with one.

- My services are rendered in a professional manner consistent the ethical standards of the American Counseling Association. If you have a complaint concerning malpractice, this can be reported to the board of licensed professional counselors.

Confidentiality

Everything we discuss in sessions will be kept confidential, except:

1. If I determine you are in imminent danger to yourself or to others;
2. If you disclose child or elder abuse/neglect;
3. If your records are subpoenaed by a court of law;
4. If you disclose sexual contact with a mental health provider with whom you have had a professional relationship;
5. If I am directed by you in writing to disclose information to someone of your choosing;
6. If you bring a malpractice suit against me

If you are experiencing an emergency situation, please go to the nearest emergency room, or call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or for free 24 hour hotline support, the Harris County Crisis Line at 713-970-7000 press option 1.

In order to provide you with the best possible services, I may discuss the details of your case with my site supervisor, Robin, who is a licensed professional counselor (LPC) and a licensed professional counselor supervisor (LPC-S).

By your signature below, you are indicating that you have read, understand, and agree to this agreement.

____ ____________________

Client/Legal Guardian Signature Date

____ ____________________

Counselor Signature Date

Houston Center for Training and Supervision
Counseling Fee Agreement

Houston Center for Training and Supervision is committed to providing affordable counseling services to the community. In an effort to do that, counseling services are provided to individuals, couples, families, and groups.

A fee of $_100.00_ per session has been assessed for counseling services that you receive at the Houston Center for Training and Supervision. Please be prepared to pay your counseling fee at the time of your counseling sessions. Checks, Zelle, Venmo, money orders, cash, and card are all acceptable forms of payment. If at any point financial circumstances arise that make counseling unaffordable at the above agreed upon rate, please inform Andrea Griggs and the fee can be reassessed on an individual basis.

During the course of your counseling, I ask that you be considerate of my time and that of other clients. Consistent attendance can make the difference between successful and unsuccessful treatment. I take seriously our commitment to help each client achieve their goals. In order to fulfill that commitment, I ask that all clients adhere to the following policies:

- 24-hour's notice is required to cancel or reschedule an appointment without penalty. Even if you are unable to provide 24-hour's notice, please contact Andrea Griggs as soon as possible if you must cancel an appointment or if you will be running late.
- No Shows or Late Cancellations will be charged the regular session fee and should be paid at the next session.
- If you are late for your scheduled session, you may not be seen. If seen, the session will end at the regular scheduled time and you will be charged the regular session fee.

By signing this agreement you agree that you have read the above information and agree to adhere to any policies put forth under the counseling program.

Client(s) Name(s) – print ____________________

If client is a minor child, name of parent/legal guardian bringing child in for services

Signature of client(s) or Parent/Legal Guardian ____________________

Date Signed ____________________