Prevail Counseling, LLC

Intake Questionnaire

Todays Date:_____

Name: _____ Sex: M / F_____

Address: _____

City/State/ZIP: _____

Home Phone: _____ Okay to Call_____ Leave a Message_____

Cell Phone: _____ Okay to Call_____ Leave a Message_____

Work Phone: _____ Okay to Call_____ Leave a Message_____

E-mail Address: _____ Okay to email YES _____ NO _____

Date of Birth: _____/_____/_____

Marital Status: Single __ Married __ In Committed Relationship __ Separated __ Divorced __ Widowed __

Partner/Spouse Name: _____

Employment status: Fulltime ____ Part-time _____Unemployed ____Homemaker _____ Student _____

Employer: _____

Occupation _____Length of employment _____

Emergency contact person: _____ Relationship to you: _____

Phone number of emergency contact: _____

Insurance Information

Primary Insurance: _____ Phone: _____

Policy #: _____ Group #: _____ Effective Date: _____/_____/____

Secondary Insurance: _____ Phone: _____

Policy #: _____ Group #: _____ Effective Date: _____/_____/____

Health Information

Name of Primary Care Physician: _____ Phone: _____

Office Address: _____

Name of Psychiatrist: _____ Phone: _____

Office Address: _____

What medications (and dosages) are you taking at present, and for what purpose?

Medication Name	Dosage	Purpose	Date Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When did you last visit a physician, and why? _____

	How often? daily/weekends	How much? 1bottle /2blunts	For how long? since high school/past 2 years	Last Use Yesterday/college
Alcohol				
Sedatives/Barbituates				
Opiates/Heroin				
Crack				
Hallucinogens				
Pot				
Cigarettes				

Problem Checklist

Please indicate which issues are problematic for you at this time by circling a number.

1= not important issue to me 4=very much a problem for me

1. Problems between husband/wife, romantic partners 1 2 3 4
2. Family problems, parenting problems, children's behavior, problems with parents, brothers, sisters 1 2 3 4
3. Problems with social skills, social life, finding friends, getting along with others 1 2 3 4
4. Trouble coping with emotions such as anger, depression, anxiety, stress, withdrawal, etc. 1 2 3 4
5. Problems with sexual functioning 1 2 3 4
6. Problems with alcohol, drugs, food, or gambling 1 2 3 4
7. Legal problems, such as divorce, custody, arrests 1 2 3 4
8. Unwed parenthood, concerns about pregnancy 1 2 3 4
9. Home management, care of the house & family members 1 2 3 4
10. Health concerns 1 2 3 4
11. Money and budgeting problems 1 2 3 4
12. Job or school related problems, such as job dissatisfaction, poor performance, unemployment 1 2 3 4
13. Domestic violence, physical/sexual abuse (past or current) 1 2 3 4
14. Trauma, Death, Serious Illness 1 2 3 4

Please check if you or anyone in your immediate family has any of the following conditions…

Alcoholism ____ Arthritis ____ Anxiety/Panic _____ Bipolar ____ Depression _____

Developmental Disabilities _____ Drug Misuse _____ Heart Disease _____ Other _____

Treatment History

Have you ever seen a psychologist or counselor for a psychological and/or emotional issue?

(for example, “1998-99, saw a counselor & took medication for depression”)

_____

Have you ever been hospitalized in an inpatient setting for a psychological/emotional issue?

_____

Have you ever been treated for drug or alcohol abuse or dependence? When?

_____

Have you ever attempted suicide? When?

_____

Have you ever harmed yourself or someone else? (ie. Self-cutting, bar fights, verbal abuse) When?

_____

Strengths, Supports, Leisure

Where do you find support? (friends, family, community involvements, spiritual)

_____

What are your personal strengths?

_____

What do you do in your spare time/ hobbies/interests?

_____

How will you know when counseling has benefited you?

_____

In your own words, share what your most important issues and concerns are:

_____

_____