HIS MERCY OUR HOPE COUNSELING LLC

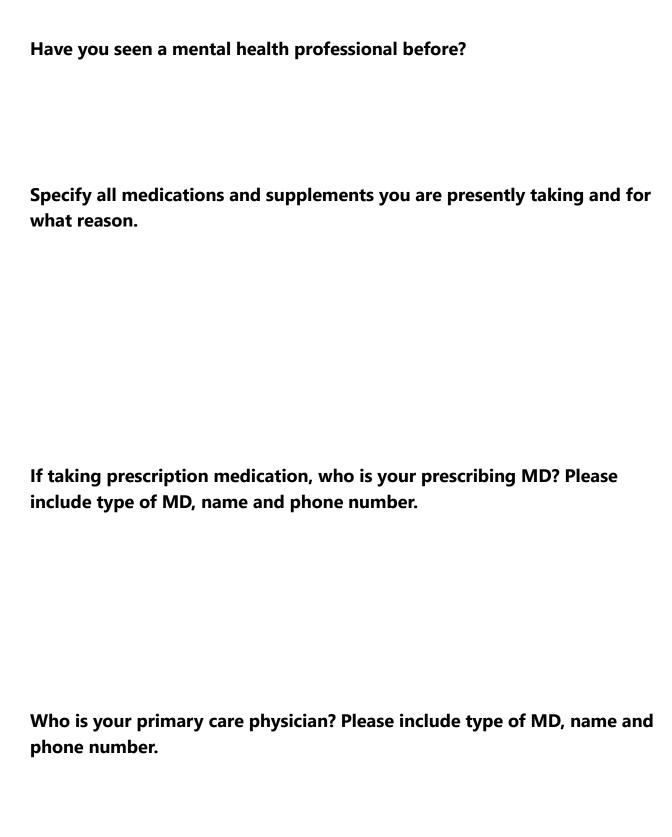
(971) 267-2345

STANDARD INTAKE QUESTIONNAIRE

What brings you to counseling at this time? Is there something speci	ific
such as a particular event? Be as detailed as you can.	

What are your goals for counseling?



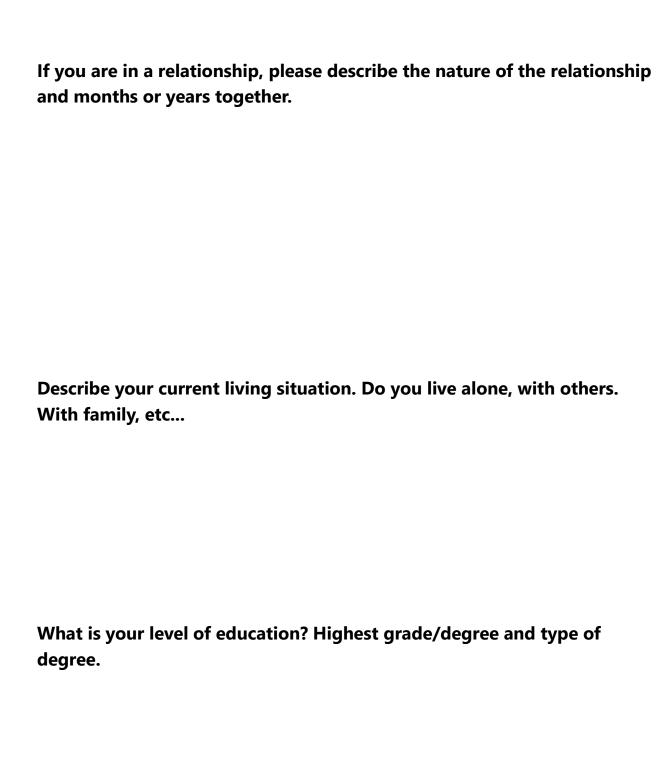




Do you drink alc	ohol? <u>(Yes/No)</u>
☐ Yes	□ No
Do you use recre	eational drugs? <u>(Yes/No)</u>
☐ Yes	□ No
Do you have suid	cidal thoughts? <u>(Yes/No)</u>
☐ Yes	□ No
Have you ever at	ttempted suicide? <u>(Yes/No)</u>
☐ Yes	□ No
Do you have tho	ughts or urges to harm others? (Yes/No)
☐ Yes	□ No
Have you ever be	een hospitalized for a psychiatric issue? (Yes/No)
☐ Yes	□ No

Is there a history of mental illness in your family? If so, identify and describe family members and their respective conditions to the best of your ability:







What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months: Increased appetite

Decreased appetite
Trouble concentrating
Difficulty sleeping
Excessive sleep
Low motivation
Isolation from others
Fatigue/low energy
Low self-esteem
Depressed mood
Tearful or crying spells
Anxiety
Fear
Hopelessness
Panic

☐ Other



Please check any of the following that apply: ☐ Headache ☐ High blood pressure ☐ Gastritis or esophagitis ☐ Hormone-related problems ☐ Head injury \square Angina or chest pain ☐ Irritable bowel ☐ Chronic pain ☐ Loss of consciousness ☐ Heart attack ☐ Bone or joint problems ☐ Seizures ☐ Kidney-related issues ☐ Chronic fatigue □ Dizziness ☐ Faintness ☐ Heart valve problems ☐ Urinary tract problems ☐ Fibromyalgia ☐ Numbness & tingling ☐ Shortness of breath ☐ Diabetes ☐ Hepatitis ☐ Asthma ☐ Arthritis ☐ Thyroid issues ☐ HIV/AIDS ☐ Cancer

☐ Other



What else would you like me to know?