IRISE Counseling Services, LLC

Client Intake Questionnaire
Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.
Personal Information

Date: _____

Name: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

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

Relationship Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Spouse or Partners name: _____ Phone number: _____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

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IRISE Counseling Services, LLC

How did you hear about IRISE Counseling Services/Laurice Harrison?

_____

INSURANCE INFORMATION

Name of Insurance Carrier _____ Member ID # _____

Policyholder's Name _____ Policy holder's DOB _____

Name of Employer _____ Group Number _____

Please note: You are required to verify your benefits before attending your first appointment. Our office will not know your exact benefits & coverage until we receive an explanation of benefits from your insurance company after the first billing.

Therapy Information

Describe the reason you are seeking counseling.

_____

_____

_____

How long has this been going on? _____

Have you experience any major stressors in the last year? (ex. death of a loved one, major illness, move, divorce, trauma, loss of employment, abuse)

_____

_____

_____

What do you consider to be some of your strengths?

_____

_____

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What do you consider to be some of your weaknesses/limitations?

_____
_____

Education and Employment

Employer _____ Job Title _____

Job Duties

_____
_____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

Are you currently in school? □ Yes □ No

School Name _____ Major _____

Highest level of Education completed _____

General Mental Health History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, previous therapist/practitioner: _____
Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:

_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list name of medications and dosage amounts

Medication name	Dosage	Prescribing Physician

Please list any **current** medication, prescribing amount and physician:

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Medication name	Dosage	Prescribing Physician

PREVIOUS TREATMENT PSYCHIATRIC HOSPITALIZATIONS
[ ] No [ ] Yes If yes, complete the following:

Age at the time	Hospital	Duration	Circumstances for treatment

General and Medical Health Information

1. How would you rate your current physical health? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:
_____
_____
_____
2. How would you rate your current sleeping habits? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:
_____
_____
3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____
4. Please list any difficulties you experience with your appetite or eating problems: _____
_____
5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long?_____
6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____
7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____
8. Do you drink alcohol more than once a week? □ No □ Yes
9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
10. Have you attempted or thought about suicide? □ No □ Yes
Please explain
_____
_____
11. What significant life changes or stressful events have you experienced recently? _____
_____
_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)
Please Circle List Family Member
Alcohol/Substance Abuse □ Yes □ No _____
Anxiety □ Yes □ No _____
Depression □ Yes □ No _____
Domestic Violence □ Yes □ No _____
Eating Disorders □ Yes □ No _____
Obesity □ Yes □ No _____
Obsessive Compulsive Behavior □ Yes □ No _____
Schizophrenia □ Yes □ No _____
Suicide Attempts □ Yes □ No _____

Are you currently in a romantic relationship? □ Yes □ No
If yes, for how long? _____
On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship

Do you have any children? If so, please list name(s), gender, and ages
_____
_____
_____

Explain your living arrangements: (People who live in your home, children's living arrangements, split custody etc.)

_____
_____
_____

SUBSTANCE USE HISTORY Family alcohol/drug abuse history: (check all that apply)
Substance use status: [ ] father [ ] mother [ ] stepparent/live-in [ ] uncle(s)/aunt(s) [ ] grandparent(s) [ ] sibling(s) [ ] spouse/significant other [ ] children [ ] other
[ ] **no history of abuse** [ ] active abuse [ ] early full remission [ ] sustained full remission [ ] sustained partial remission Issues related to substance abuse: [ ] hangovers [ ] seizures [ ] blackouts [ ] overdose [ ] assaults [ ] binges [ ] job loss [ ] arrests [ ] suicidal impulse [ ] sleep disturbance [ ] withdrawal symptoms [ ] medical conditions [ ] tolerance changes [ ] loss of control of amount used [ ] relationship conflicts

Substances used: [ ] Alcohol [ ] amphetamines/speed [ ] barbiturates/owners [ ] caffeine [ ] cocaine [ ] crack cocaine [ ] hallucinogens (e.g., LSD) [ ] heroin [ ] inhalants (e.g., glue, gas) [ ] marijuana or hashish [ ] nicotine/cigarettes [ ] PCP [ ] prescription: [ ] other: First use age: Current use? (Yes/No) Last use age:

Please explain if you selected any drugs above:

_____
_____
_____

Trauma History: sexual/physical/mental: □ Yes □ No

Experience or currently in a domestic abuse relationship □ Yes □ No

If yes, please explain

_____
_____

Developmental History: (Learning delay/disabilities)

_____
_____

Legal History
Have you ever been arrested? □ Yes □ No
If yes, please explain

_____
_____