1st Step Counseling
1525 Western Ave, Ste. 4
Albany NY 12203-3536
(518) 629-5409

Standard Intake Questionnaire

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms (check all that apply)

- Anxiety ☐
- Appetite Issues ☐
- Avoidance Crying ☐
- Spells ☐
- Depression ☐
- Excessive Energy ☐
- Fatigue ☐
- Guilt ☐
- Hallucinations ☐
- Impulsivity ☐
- Irritability ☐
- Libido Changes ☐
- Loss of Interest ☐
- Panic Attacks ☐
- Racing Thoughts ☐
- Risky Activity ☐
- Sleep Changes ☐
- Suspiciousness ☐

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?(check all that apply)

Alcohol ☐
Tobacco ☐
Marijuana ☐

Hallucinogens (LSD) ☐
Heroin ☐
Methamphetamines ☐
Cocaine ☐
Stimulants (Pills) ☐
Ecstasy ☐
Methadone ☐
Tranquilizers ☐
Pain Killers ☐

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want the doctor to know?: