



Intake Questionnaires

Client Name _____ Today's Date _____

Address _____ Birthdate _____

_____ Phone _____

Emergency contact: _____

Ideally someone local Name _____ Phone _____

Relationship to me: _____

(e.g., roommate, landlord, friend, relative, spouse, parent)

The following demographic questions are asked in a relatively non-categorical way, recognizing that people don't fit neatly into boxes. Sometimes it can be helpful for me to know this information so I can work with you in an appropriate and sensitive way. You are welcome to decline to answer any question.

Gender identity: _____

(e.g., non-binary, female, male, transgender, fluid, intersex, prefer not to say)

Sexual orientation: _____

(e.g., bisexual, lesbian, gay, queer, heterosexual, prefer not to say)

Ethnic identity: _____

(e.g., African descent, Latino/a/x, Korean, South Asian, African American, Native American, Persian, Northern European, Irish, Mediterranean, etc., prefer not to say)

Spirituality or faith: _____

(e.g., spiritual but not religious, Catholic, Buddhist, atheist, agnostic, Zoroastrian, Jewish, etc., prefer not to say)

Subcultures you belong to or identify with: _____

(e.g., hunter, military veteran, artist, Burner, evangelical Christian, etc., prefer not to say)

Occupation/work: _____

(e.g., teacher, manufacturing, gardening, retail, raising children, farmer, etc., prefer not to say)

Employment status now: _____

(e.g., full time, part time, retired, unemployed, etc.)

Questions that may be relevant to your mood:

What activities or hobbies do you really enjoy doing? (e.g., knitting, folk dance, hiking, skiing, collecting insects, crafting, journaling, drinking coffee, hanging out with friends)

What is your diet typically like? (e.g., standard American diet, pretty healthy, pre-prepared meals, vegetarian, gluten-free, a lot of fast food, Mediterranean diet, keto, etc.)

Questions about your brain health:

Have you ever been deprived of oxygen for a period of time greater than 5 minutes? If so, briefly describe what happened.

Have you ever experienced a blow to the head that caused you to become disoriented or to lose consciousness? If so, briefly describe what happened.

Have you ever been exposed to a toxic substance, such as carbon monoxide or a solvent, that might have caused damage to your brain? If so, briefly describe what happened.

Questions about your mood and mental health:

Have you ever been diagnosed with a mood or other mental health condition?

If so, what was the diagnosis? (e.g. depression, bipolar I, bipolar II, cyclothymia, PTSD, anxiety disorder, etc.)

When did this diagnosis occur?

What previous treatment have you had for mental health? (e.g., medication, psychotherapy, group therapy, etc., providers and dates)

Questions about your health:

What medications are you currently taking? Include over-the-counter medicines, like allergy medicines, vitamins, or supplements.

Medication/supplement	Dose	When taken & how often	Why taken
e.g. Vitamin D	1,000 IU	In the a.m., 1x/day	General health
e.g. cetirizine (generic Zyrtec)	10 mg	Evening, 1x/day	Seasonal allergies

In treating mental health issues, it can be helpful to know what else might be going on.

Check any of the conditions below that you have ever had or been diagnosed with.

- Fibromyalgia
- Vision impairment
- Hearing impairment
- Arthritis
- Autism spectrum or Asperger's syndrome
- Attention Deficit Hyperactivity (ADHD)
- Other learning disability
- Narcolepsy
- Central sleep apnea
- Chronic pain
- Chronic fatigue
- Asthma
- Broken bones
- Torn ligaments or tendons
- Asthma
- Restless legs syndrome
- Obstructive sleep apnea
- Any circadian rhythm syndrome

___ Anorexia, bulimia, or related condition

Are you allergic to cats? _____

Are you allergic to dogs? _____

(Relevant in case any other client requests to bring in a therapy animal, I need to know whether to say no because of allergies)

Are there any other medical factors that you think might be affecting your mood? (Questionnaires on following pages ask about stress, so you do not need to list that here.)

On the following pages are questionnaires that will be helpful to me in working with you.

Insomnia Severity Index

For each question, please CIRCLE the number that best describes your answer.

Please rate the *CURRENT* (i.e. *LAST 2 WEEKS*) *SEVERITY* of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied Satisfied Moderately Satisfied Dissatisfied Very Dissatisfied
 0 1 2 3 4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all
 Noticeable A Little Somewhat Much Very Much Noticeable
 0 1 2 3 4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all
 Worried A Little Somewhat Much Very Much Worried
 0 1 2 3 4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all
 Interfering A Little Somewhat Much Very Much Interfering
 0 1 2 3 4

Sleep Need Questionnaire

Client Name _____ Date _____

Please answer these questions based on your experience during the previous week.

This past week:	Never 1	Rarely 2	Sometimes 3	Frequently 4	Always 5
Did you feel tired or fatigued (low energy) during the day or evening before bedtime?					
Were you sleepy or drowsy (eyelids heavy) during the day or evening before bedtime?					
Did you take any naps or fall asleep briefly during the day or evening before bedtime?					
Did you feel you had been getting an adequate amount of sleep?					

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A numeric measure of personal stress can be determined by using a variety of instruments that have been designed to help measure individual stress levels. One of these is the Perceived Stress Scale, originally developed in 1983, which can help show how different situations affect feelings and perceived stress.

Perceived Stress Scale

The questions in this scale ask about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question.

The best approach is to answer fairly quickly. That is, don't try to count up the number of times you felt a particular way; rather indicate the alternative that seems like a reasonable estimate.

Put a <input checked="" type="checkbox"/> or an <input type="checkbox"/> in the appropriate box:	Never 0	Almost never 1	Some- times 2	Fairly often 3	Very often 4	
1. In the last month, how often have you been upset because of something that happened unexpectedly?						
2. In the last month, how often have you felt that you were unable to control the important things in your life?						
3. In the last month, how often have you felt nervous and stressed?						
4. In the last month, how often have you felt confident about your ability to handle your personal problems?						R
5. In the last month, how often have you felt that things were going your way?						R
6. In the last month, how often have you found that you could not cope with all the things that you had to do?						
7. In the last month, how often have you been able to control irritations in your life?						R
8. In the last month, how often have you felt that you were on top of things?						R
9. In the last month, how often have you been angered because of things that happened that were outside of your control?						
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?						

Used with permission from the State of New Hampshire Employee Assistance Program.

On the next two pages are NIH (National Institutes of Health) questionnaires used to measure life satisfaction, anxiety, and mood. These questionnaires are publicly available with permission to use them.

Domain-Specific Life Satisfaction (Ages 18+) – Fixed Form

Please respond to each question or statement by marking one box per row.

Indicate how much you agree or disagree...		Not at all	A little bit	Somewhat	Quite a bit	Very much
PA077	I am satisfied with my education.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA078	I am satisfied with my present job or work.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA079	I am satisfied with my well-being from spiritual, religious or philosophical beliefs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA080	I am satisfied with my housing.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA081	I am satisfied with my family life	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA082	I am satisfied with my health	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA083	I am satisfied with my friends and social life.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA084	I am satisfied with my neighborhood overall.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA085	I am satisfied with my ability to help others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA086	I am satisfied with my achievement of my goals	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA087	I am satisfied with my leisure	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA088	I am satisfied with my physical safety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PA089	I am satisfied with my energy level	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Please respond to each question or statement by marking one box per row.

In the past 7 days...		Never	Rarely	Sometimes	Often	Always
EDDEP29	I felt depressed.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP41	I felt hopeless.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP09	I felt that nothing could cheer me up.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP48	I felt that my life was empty.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP04	I felt worthless.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP36	I felt unhappy.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP39	I felt I had no reason for living.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP45	I felt that nothing was interesting.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Please respond to each question or statement by marking one box per row.

In the past 7 days:

		Never	Rarely	Sometimes	Often	Always
Anxiety36	I felt fearful.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Anxiety39	I felt anxious.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Anxiety51	I felt worried.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Anxiety54	I found it hard to focus on anything other than my anxiety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Anxiety57	I felt nervous.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Anxiety62	I felt uneasy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Anxiety63	I felt tense	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Thoughts about suicide are common – most people in the U.S. have had a period of time where they had such thoughts. This is a questionnaire from the STABLE Project (Standards for Bipolar Excellence Project), used to measure thoughts and behaviors related to suicide. Colorado has a 24-hour/365-day/year Crisis Line if you feel you are in danger of acting on such thoughts very soon: 1-844-493-8255 or text T-A-L-K to 38255. (This questionnaire is publicly available with permission to use it.)

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- 1. Never
- 2. It was just a brief passing thought
- 3a. I have had a plan at least once to kill myself but did not try to do it
- 3b. I have had a plan at least once to kill myself and really wanted to die
- 4a. I have attempted to kill myself, but did not want to die
- 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- 1. Never
- 2. Rarely (1 time)
- 3. Sometimes (2 times)
- 4. Often (3-4 times)
- 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- 1. No
- 2a. Yes, at one time, but did not really want to die
- 2b. Yes, at one time, and really wanted to die
- 3a. Yes, more than once, but did not want to do it
- 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- 0. Never
- 1. No chance at all
- 2. Rather unlikely
- 3. Unlikely
- 4. Likely
- 5. Rather likely
- 6. Very likely

Instructions

The goal of this exercise is to increase awareness of what really matters to you by identifying your top five life values. Values are the answer to the questions: What's important to you in your life? What is your life's purpose? What do you enjoy doing? When do you feel satisfied and fulfilled? Being aware of your values by answering the above questions will help you navigate your life in the direction that you choose. You have the potential to live the life of your dreams, but how do you do this without looking inward? Understanding our own core values help guide us towards our passions and desires. Please complete the five steps below.

1. Take ten minutes to brainstorm what your own values are without referring to the list on the next page.

My values are:

.....

.....

.....

.....

.....

2. Review the values list on the next page and check those values that resonate with you.
3. This list is always a work-in-progress. If you wish, you may add other values from your brainstorming session or those that you think of along the way through this process:

.....

.....

.....

.....

.....

Values list:

Acceptance	Fairness	Peace
Achievement	Fame	Personal Development
Advancement & Promotion	Family Happiness	Personal Expression
Adventure	Fast Pace	Planning
Affection	Freedom	Play
Altruism	Friendship	Pleasure
Arts	Fun	Power
Awareness	Grace	Privacy
Beauty	Growth	Purity
Challenge	Harmony	Quality
Change	Health	Radiance
Community	Helping Others	Recognition
Compassion	Helping Society	Relationships
Competence	Honesty	Religion
Competition	Humour	Reputation
Completion	Imagination	Responsibility & Accountability
Connectedness	Improvement	Risk
Cooperation	Independence	Safety & Security
Collaboration	Influencing Others	Self-Respect
Country	Inner Harmony	Sensibility
Creativity	Inspiration	Sensuality
Decisiveness	Integrity	Serenity
Democracy	Intellect	Service
Design	Involvement	Sexuality
Discovery	Knowledge	Sophistication
Diversity	Leadership	Spark
Environmental Awareness	Learning	Speculation
Economic Security	Loyalty	Spirituality
Education	Magnificence	Stability
Effectiveness	Making a Difference	Status
Efficiency	Mastery	Success
Elegance	Meaningful Work	Teaching
Entertainment	Ministering	Tenderness
Enlightenment	Money	Thrill
Equality	Morality	Unity
Ethics	Mystery	Variety
Excellence	Nature	Wealth
Excitement	Openness	Winning
Experiment	Originality	Wisdom
Expertise	Order	
Exhilaration	Passion	

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