Family Wellness Counseling

Intake Questionnaire

8211 E. Regal Blvd Suite 100
Tulsa, OK 74133
918-604-2007
info@fwctulsa.com

Personal Information

Name: ______________________________________ Date: _________________________

Parent/Legal Guardian (if under 18): ____

Address: ____

Home Phone: ________________________________ May we leave a message: ☐ Yes☐ No

Cell/Work/Other Phone: _______________________ May we leave a message: ☐ Yes☐ No

Email: ____

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

Date of Birth: ____________________ Age: ______ Gender: _________________________

Marital Status:

☐ Married ☐ Domestic Partnership ☐ Separated

☐ Never Married ☐ Widowed ☐ Divorced

Referred by (if any): ____

How did you hear about Family Wellness Counseling? ____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ____

____

Are you currently taking any prescription medications? If so please list them below.

Medication/Supplement	Dosage	Date Began	Reason	Doctor

Physical Health Information

1. How would you rate your current physical health?

☐ Poor ☐ Fair ☐ Good

2. Please list any specific health problems you are currently experiencing. _________________________

____

3. How do these problems affect your daily functioning? ____

____

4. How would you rate your current sleeping habits?

☐ Poor ☐ Fair ☐ Good

5. Please list any specific sleep problems you are currently experiencing. _________________________

____

6. Do you ever have difficulty falling asleep? ☐ Yes ☐ No

7. Do you ever have difficulty staying asleep? ☐ Yes ☐ No

8. How many hours do you think you sleep each night (on average)? _________________________

9. How would you rate your current diet?

☐ Poor ☐ Fair ☐ Good

10. Please list any difficulties you experience with your appetite or eating problems. _______________

____

11. Do you exercise? ☐ Yes ☐ No

12. If yes, please describe how often you exercise and what type of exercise you do. _______________

____

Mental Health Information

1. Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, for approximately how long? ____

2. Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ Yes ☐ No

If yes, when did you begin experiencing this? ____

3. Are you currently experiencing chronic pain? ☐ Yes ☐ No

If yes, for approximately how long? ____

4. Please describe your current use of alcohol, cigarettes, and/or recreational drugs.

If you are not using any of these substances please check none. ☐ None

Substance	Frequency	Amount	Age Started	Last Time Used

Family History

Where were you born? ____

Where did you live throughout childhood? ____

____

Please list your parents and siblings.

Name	Age	Relationship, and if deceased, their age and cause of death.

How would you describe your life at home as a child (e.g., calm, chaotic, conflict, etc.) ______________

____

____

In the section below please identify if there is a family history of any of the following:

Condition		Family Member/Relationship
Alcohol/Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Sexual Abuse	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No	
Obsessive Compulsive Disorder	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide attempts	☐ Yes ☐ No	
Other: ___________________________	☐ Yes ☐ No	

How would you describe your **current** life at home (e.g., calm, chaotic, conflict, etc.) ________________

____

____

Please list your immediate family members.

Name	Age	Relationship, and if deceased, their age and cause of death.

Additional Information

What do you enjoy doing in your free time (e.g., hobbies, activities, etc.) ___________________________

____

Do you consider yourself to be spiritual or relgious? If yes, please describe your belief.

____

____

What do you consider to be some of your strengths? ____

____

What do you consider to be a weakness? ____

____

What do you hope to accomplish through the counseling services? _________________________________

____

____

Client Signature: ____ Date: ____________________

Counselor Signature: _______________________________________ Date: ____________________