

# Logstrom Counseling Intake Questionnaire

To best meet your needs, the information below will maximize your time here. Please allow 30-60 minutes to complete this survey prior to your first appointment. Write "N/A" for anything that does not apply.

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

DATE OF COMPLETION: \_\_\_\_/\_\_\_\_/\_\_\_\_

## COUNSELING FOCUS

CIRCLE any problems that are significantly bothering you:

- |                        |                         |                        |                       |                   |
|------------------------|-------------------------|------------------------|-----------------------|-------------------|
| <i>Depression</i>      | <i>Emotional</i>        | <i>Employment</i>      | <i>Housing</i>        | <i>Disability</i> |
| <i>Anxiety</i>         | <i>health</i>           | <i>Finances</i>        | <i>Addiction—self</i> | <i>Lifestyle</i>  |
| <i>Grief/Loss</i>      | <i>Spiritual health</i> | <i>Legal issues</i>    | <i>Addiction—</i>     | <i>Self-harm</i>  |
| <i>Anger/violence</i>  | <i>Sexuality</i>        | <i>Military issues</i> | <i>other</i>          |                   |
| <i>Physical health</i> | <i>Relationships</i>    | <i>Cultural issues</i> | <i>Abuse</i>          |                   |
| <i>Mental health</i>   | <i>Education</i>        | <i>Social life</i>     | <i>Trauma</i>         |                   |

Chief areas of stress during last year:

Area	Low	Med	High	Impact on you

Please summarize the reasons that led you to seek counseling services:

---

---

---

---

---

---

---

---

---

---

You will now have the opportunity to provide more detail regarding the problems and stresses in your life. Please include any important history of each problem. Additional information can be written at the end of this survey.

# Logstrom Counseling Client Intake Questionnaire

## FINANCES

Describe any problems related to finances:

---

---

## LEGAL ISSUES

Describe any problems with legal matters: (Circle) Civil / Criminal

---

---

Are you on probation? \_\_\_ Y \_\_\_ N Give details: \_\_\_\_\_

Are you on parole? \_\_\_ Y \_\_\_ N Give details: \_\_\_\_\_

## CULTURE

What is your racial or ethnic background?

---

---

Describe any problems related to race or ethnicity:

---

---

## EDUCATION/EMPLOYMENT

State your completed education/training, and list the highest degree obtained, including any major:

---

---

How did you do academically? \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

If you are currently a student, state where, and what degree or certification you are pursuing:

---

---

Learning disabilities: \_\_\_ Y \_\_\_ N if yes, describe disability:

---

---

State your current employment and length of time there:

---

---

Please briefly summarize your work history:

---

---

Describe any problems related to school or work:

---

---

## HOUSING

Do you live independently? \_\_\_ Y \_\_\_ N Type of residence: \_\_\_\_\_

Describe any threat to your housing situation: \_\_\_\_\_

## MILITARY SERVICE

Which branch? \_\_\_\_\_ Active duty? \_\_\_ Y \_\_\_ N

In combat? \_\_\_ Y \_\_\_ N Where? \_\_\_\_\_

If discharged, was it "Honorable"? \_\_\_ Y \_\_\_ N Year & rank \_\_\_\_\_

Describe any problems related to your military experience:

---

---

# Logstrom Counseling Client Intake Questionnaire

## SPIRITUALITY/RELIGION

State any denomination, church, or group you were raised in:

\_\_\_\_\_

State any denomination, church or group you are now attend:

\_\_\_\_\_

How active or involved are you:

\_\_\_\_\_

Briefly summarize your beliefs:

\_\_\_\_\_

Describe any problems related to spirituality or religion:

## SEXUALITY/REPRODUCTION

Describe any problems regarding sexuality:

\_\_\_\_\_

State the year of any miscarriages:

\_\_\_\_\_

State the year of any abortions:

\_\_\_\_\_

Number of all sexual partners: \_\_\_\_\_ List any STDs: \_\_\_\_\_

## FAMILY AND SIGNIFICANT RELATIONSHIPS

CURRENT marital status: (Check all that apply)

Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Cohabiting \_\_\_\_\_

FORMER marital status: (Check all that apply)

Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Cohabiting \_\_\_\_\_

For each marriage or serious relationship, state the name, type, time frame, and quality:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Whom are you currently living with? Describe your family/living companions:

\_\_\_\_\_

List all children, stepchildren, or other children raised by you:

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Current age: \_\_\_\_\_ Related how: \_\_\_\_\_

Lived with you: Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ Short time \_\_\_\_\_ Never \_\_\_\_\_

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Current age: \_\_\_\_\_ Related how: \_\_\_\_\_

# Logstrom Counseling Client Intake Questionnaire

Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_

List anyone else for whom you are the primary caretaker: (Ill, disabled)

---



---

You were raised by: (Describe quality of each relationship)

---



---



---

List all sibling, half-siblings, stepsibling, or other children were raised with you:

Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_  
 Lived with you: Full-time \_\_\_ Part-time \_\_\_ Short time \_\_\_ Never \_\_\_  
 Name: \_\_\_\_\_ Gender: \_\_\_ Current age: \_\_\_ Related how: \_\_\_\_\_

## PHYSICAL HEALTH AND MEDICAL INFORMATION

Health concern or medical condition	Current or past	Treatment for condition	Treating doctor	Any limitations due to medical condition

Please describe any head traumas throughout your life:

---



---

Please describe any significant accidents, injuries:

---



---

Describe any health changes in the last year:

---

# Logstrom Counseling Client Intake Questionnaire

How is your health overall? \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

List all medications you are CURRENTLY taking: (including over the counter)

Medication      Dosage      For what issue      Prescribing MD      How long on medication

---



---



---



---



---

Describe your mental health treatment history:

Treatment (inpt/outpt)	Agency/Therapist	Dates of Service	How helpful

State any current or past chemical use:

Substance	Current or past	Frequency and amount	Age started
Alcohol abuse			
Marijuana			
Cocaine			
Methamphetamine			
LSD/Mushrooms			
Heroin			
Inhalants			
Nicotine			
Other			
Other			
Other			

Family history of mental health concerns:

Note any "blood" relatives who have or had problems with any of the following

Check Problem	Which family member	Current Status
Substance abuse		
Depression		
Bi-Polar Disorder		
Schizophrenia		
Other Emotional Problems		

## ASSESSMENT OF ABUSE

Abuse	Current	Past	Perpetrator, victim or witness	Please describe any outside intervention, such as treatment, child protection, the legal system, etc.
Mental				
Emotional				
Spiritual				

# Logstrom Counseling Client Intake Questionnaire

Physical				
Sexual				

Please describe the nature of the abuse, when it occurred, the duration of the abuse, who was involved, and the harm it caused you or others:

---

---

---

---

## SAFETY CONCERNS

Describe any risk of harm to SELF:

Type of harm? \_\_\_\_\_

Toward whom? \_\_\_\_\_

Thoughts or actions? \_\_\_\_\_

Past or current? \_\_\_\_\_

Was this planned out? \_\_\_\_\_

Describe any risk of harm to OTHERS:

Type of harm? \_\_\_\_\_

Toward whom? \_\_\_\_\_

Thoughts or actions? \_\_\_\_\_

Past or current? \_\_\_\_\_

Was this planned out? \_\_\_\_\_

## PERSONAL RESOURCES

Describe your current support system: (family, friends, church, neighbors, co-workers, etc.)

---

---

---

---

Describe your social activities, interests, and hobbies:

---

Describe your strengths:

---

WHAT ARE YOUR GOALS AND EXPECTATIONS OF THERAPY/COUNSELING?

---

---

---