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## INTAKE QUESTIONNAIRE

PLEASE TAKE THE TIME TO COMPLETE THIS INTAKE QUESTIONNAIRE. THE QUESTIONS ARE EXTENSIVE AND QUITE PERSONAL. THE MORE INFORMATION YOU CAN PROVIDE BEFORE YOUR INTAKE APPOINTMENT, THE BETTER I CAN PREPARE. IT ALSO GIVES YOU A CHANCE TO SAY THINGS IN YOUR OWN WORDS RATHER THAN HAVING ANOTHER PERSON, ME, PUT YOUR EXPERIENCE IN MINE AND TO DO THIS IN THE COMFORT OF YOUR OWN HOME.

Today's date:

1. Please briefly describe your reason for seeking services now, and any current symptoms or concerns you are experiencing.
  - 1b. How long have you been experiencing these symptoms/ issues? When did they first occur? How has it changed over time (has it ever been better or worse)? Do you have a family history of mental health issues?
  - 1c. In what ways is this issue/ are these issues impacting you in your life right now? What can you not do or not do as well because of your mental health issues (e.g., activities of daily living, school, work, social functioning)?
2. What are your goals for therapy? Differently put, what changes would you like to see? And, how will we know that therapy is done?



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3. Have you had any previous mental health treatment (if so When, Where and What did you like/ dislike about your previous experience)?
  
  
  
  
  
  
  
  
  
  
4. Have you ever been hospitalized due to mental health concerns (if so when, where)?
  
  
  
  
  
  
  
  
  
  
5. Do you have a primary care provider (Please list their name and contact information)?
  
  
  
  
  
  
  
  
  
  
- 5b. Do you have any physical health issues you are currently being treated for? How would you rate your overall health (as excellent, good, fair, poor)?
  
  
  
  
  
  
  
  
  
  
- 5c. Have you filled out an authorization to use and disclose health information for this provider?
  
  
  
  
  
  
  
  
  
  
- 5d. How many hours of sleep are you getting on average per night? How would you rate the quality of your sleep? Please describe any concerns you may have about your sleep, including difficulty falling asleep, difficulty staying asleep, oversleeping, insomnia, nightmares).
  
  
  
  
  
  
  
  
  
  
- 5e. How would you describe your diet? Are you skipping meals, are you getting a variety of nutritious foods? Has your weight changed significantly recently (either gained or lost weight without trying)? How so?



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- 5f. What do you do for exercise? Please list activities you engage in, how frequently you engage in them and how long for. Are you hoping to change anything about your level of activity?
- 5g. Do you consume any caffeine (coffee, tea, soda)? How much? Have you noticed any impact on your mental health symptoms or sleep when you consume caffeine?
6. Do you take medications to treat your mental health symptoms? If so, what medications are you taking, how long have you been taking them for, are you taking them as prescribed and who prescribes them? (If other than your primary care provider, please list their name and contact information). Do you have any side effects from the medications?
- 6b. Have you filled out an authorization to use and disclose health information for this provider?
7. Do you use any alcohol (What, Frequency, Amount)? Do you ever use more alcohol than you intended? Does your alcohol consumption cause issues with the law, family and friends or work? Do you use despite negative physical or mental effects?
8. Do you use any non-prescribed substances (What, Route of use, Frequency, Amount)? Do you ever use more than you intended? Does your use cause issues with the law, family and friends or work? Do you use despite negative physical or mental effects?



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9. Have you ever attempted suicide? If the answer is yes, please describe what year this happened, by what means you attempted to kill yourself and if you needed medical attention as a result. Please also state when you last had thoughts of suicide and give an example of a thought that went through your head. (If you have concern about honestly providing information on this topic, please talk to me about it so I can ease your concerns!)
  
10. If the answer was no, Have you ever had thoughts of suicide? When did you last have thoughts of suicide and please give an example of a thought that went through your head.
  
11. Have you ever had thoughts of self-harm? When was the last time you had such thoughts? Please give an example of a thought that crossed your mind.
  
12. Have you ever self-injured? If yes, when was the last time and by what means?
  
13. Have you ever had thoughts of physically hurting another person? If yes, please describe an example thought that went through your head and when you last had thoughts of hurting anyone.
  
14. Have you ever physically hurt another person? If yes, when did this occur; what was your relationship to this person and how did you hurt them? (No judgment from me. I just need to know!)





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20. Where do you work and what is your role? How long have you had this job? What is important for me to know about your work history or experience?
  
21. Have you ever been houseless? When was this and how long did this last?
  
22. Have you experienced trauma, i.e., an event where you were afraid for your life or the life of someone you love? Have you experienced sexual assault? (I know these can be difficult to answer or even read. I want to give you an opportunity to tell me about this in a way that feels the most safe to you and for a lot of people that is putting it in writing as opposed to having to say it out loud the first time they meet someone.)
  
23. What do you see as your strengths and who is in your support systems? What tools have been helpful for you in trying to cope with your issues?
  
24. Anything else you would like me to know?



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25. How did you find me?

Please print your name here:

THANK YOU SO VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS EXTENSIVE QUESTIONNAIRE.