Healing Bear Wellness
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Intake Questionnaire

Please fill out this intake form to the best of your ability. All materials contained in this form will remain strictly confidential.

Name: _____

Name of parent/guardian (if under 18 years of age):

_____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Email: _____

OK to email? _____ Yes _____ No (Please note that email correspondence is not considered to be a confidential medium of communication)

Home phone: _____ Daytime number: _____

Cell phone: _____ OK to leave messages? _____ Yes _____ No

How did you hear about Healing Bear Wellness LLC? _____

_____

Birthdate: _____ Age: _____ Gender: _____

Your relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Cultural and/or Ethnic Identification: _____

Spiritual and/or Religious Identification: _____

Children (gender, age): _____

Others living in the home: _____

Person to alert in the event of medical emergency: _____

Relationship to you: _____ Phone: _____

Education: _____

Occupation/Employment: _____

How many hours per week? _____

Satisfaction level with work/occupation/employment? _____

Present Concerns

Please describe the reason(s) for seeking counseling (include date the concern started):

_____

_____

Personal History

Past Counseling or Mental Health Services

Psychological or psychiatric treatment of any kind before? ___ Yes ___ No

What type of care was received? Outpatient _____ Inpatient _____

When was the treatment? _____

How long was the treatment? _____

Was there prescribed medication? ___ Yes ___ No

If yes, what was prescribed (include dosages if known)?

_____

_____

Are you currently taking any prescription medication? ___ Yes ___ No

If so, what type (include dosages if known):

_____

_____

Family history of psychological or psychiatric treatment:

_____

_____

Symptoms

Please check if any of the following symptoms/problems/complaints are affecting you:

___ Eating/Appetite concerns
___ Sleeping difficulties
___ Decreased energy/Fatigue
___ Stress
___ Muscle tension
___ Unable to relax
___ Depression
___ Feeling alone
___ Trouble with daily activities
___ Isolation
___ Sexual concerns
___ Loss of interest in activities
___ Change in social interests
___ Tearfulness
___ Hopelessness/Helplessness
___ Decreased attention span
___ Inattentive/Distractible
___ Memory concerns
___ Difficultly planning ahead
___ Opposition
___ Anger outbursts
___ Impulse control
___ Mood changes
___ Anxiousness/Nervousness
___ Worry/Fear
___ Stealing
___ Lying
___ Legal problems
___ Money and financial concerns
___ Housing difficulties
___ Panic attacks
___ Rapid heart rate
___ Dizziness
___ Fainting
___ Numbness or tingling
___ Phobia
___ Sweating
___ Trouble breathing
___ Flashbacks of traumatic event
___ Nightmares
___ Racing thoughts
___ Hearing voices
___ Seeing things
___ Illness or physical health problems
___ Being a caregiver
___ Spiritual or Religious concerns
___ Conflict with an important person
___ Separation from loved one
___ Grief and/or loss
___ Death of an important person
___ Suicidal ideation
___ Suicide attempt
___ Self-harm
___ Homicidal ideation

___ Drug use/abuse
___ Alcohol use/abuse
___ Work/School concerns
___ Family concerns
___ Marital/Relationship concerns
___ Friendship concerns

Other concern(s) not listed:

_____

_____

Physical and Medical

How would you rate your current physical heath?

___Poor
___Unsatisfactory
___Satisfactory
___Good
___Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

Sleep:

How many hours of sleep do you get a night on average? _____

Do you typically feel rested? ___ Yes ___ No

Any concerns (i.e. falling and/or staying asleep)?

_____

_____

Exercise:

Do you exercise or get physical activity on a consistent basis? ___ Yes ___ No

If so, how many hours a week? _____ Type of activity:

Any concerns (i.e. injuries, inactivity, etc)?

Medical:

Major accidents, surgeries, medical problems, illnesses, and/or traumatic events (include date(s)):

Date of last physical exam: _____

Under current medical treatment: ___ Yes ___ No

If so, why: _____

Current medications:

Over the counter medications:

Allergies:

Eating and Nutrition:

How many meals do you eat a day on average? _____

Do you typically feel like you get enough nutrition? ___Yes ___ No

Any concerns (i.e. not getting enough or getting too many calories)?

_____

_____

_____

Substance Use

Caffeine: ___ Yes ___ No Type: _____# of drinks per day: _____

Tobacco: ___ Yes ___ No Type: _____ Use per day: _____

Alcohol: ___ Yes ___ No Type: _____ # per day: ___ week: _____

Other drugs: ___ Yes ___ No Type/frequency of use: _____

_____

Describe the impact of substance use on your life:

_____

_____

_____

Past treatment for substance use (if any):

_____

_____

_____

Family history of substance use (if any):

_____

Relationship:

Romantic

Are you currently in a romantic relationship? ___ Yes ___ No

If yes, for how long? _____

How would you describe your relationship?

Satisfaction level of relationship?

Past significant romantic relationships and/or marriages:

Sexual:

Is your sex life satisfactory? ___ Yes ___ No

If not, what are your concerns

In my opinion, sex is:

Family Structure:

Who do you currently live with and/or consider a part of your immediate family?

How would you describe your family?

Friendships:

How would describe your friendships and/or social life?

Family of Origin:

Siblings: ___ Yes ___ No

If so, name(s) & age(s):

How would you describe you family upbringing?

Significant events (I.e. divorce, abuse, etc.):

Current family or origin relationships (i.e. who are you close and in contact with?):

Personal Interests:

Please list some of your interests and/or hobbies:

How is most of your free time occupied?

What significant life changes or stressful events have you experienced recently?

Please list a few of your strengths:

Please list a few areas that you find challenging or consider weaknesses:

What would you like to accomplish out of your time in counseling?

Motivation for counseling:

Other Information that you would like to provide: