EVOLVE
COUNSELING ✣ WELLNESS
Dorian Race, D.C., M.S.
1550 Lake Baldwin Lane, Suite B ♦Orlando, FL 32814 ♦407.616.5948 ♦evolvecounselingorlando.com

CLIENT INTAKE QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Gender: M F

Mailing Address: _____

_____ May I send mail here? Y N

Email Address: _____ May I email you here? Y N

Mobile Phone Number: _____ May I call/text you here? Y N

Home Phone Number: _____ May I call you here? Y N

How do you prefer to be contacted? EMAIL TEXT CELL PHONE HOME PHONE

Emergency Contact: _____ Relationship: _____

Mobile Phone: _____ Home Phone: _____

PRESENTING ISSUES AND GOALS

Please briefly describe the circumstances that led you to seek counseling at this time:

_____

_____

What do you hope to gain or change as a result of counseling?

_____

_____

Have you received counseling elsewhere previously? (if so, please briefly describe your experience):_____

_____

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EMPLOYMENT INFORMATION

Are you currently employed outside of the home? Y N

Employer: _____Length of Employment: _____

Occupation: _____ Average Hours Worked per Week: _____

RELATIONSHIP INFORMATION

Current Relationship Status: Married Single Dating Engaged Divorced Widowed

Are you content with your current relationship status? YES NO

If married, how long? _____ Partner's Name: _____

Number of previous marriages: You: _____ Your partner: _____ If separated, divorced or widowed, how long? _____

What words would you use to describe your partner? _____

_____

Is your partner supportive of you seeking counseling? _____

With whom do you currently live? _____

Do you have a personal support system? _____

SUBSTANCE USE

Do you drink alcohol? _____ How often? _____ How much? _____

Have you ever felt the need to cut down on your drinking? _____

Has anyone ever expressed concern about your drinking? _____

Have you ever had a drink first thing in the morning to calm your nerves? _____

Do you drink caffeine? _____ How often? _____ How much? _____

Do you use any other substances? _____ If yes, what type? _____

How often? _____ How much? _____

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MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

Are you currently receiving treatment for a medical condition? Y N If yes, please explain: _____

_____

Please list any conditions, illnesses, hospitalizations, surgeries or accidents you have had in the past.

_____

_____

Current Medications: Please list all current medications, along with daily dosage and what it is prescribed for:

_____

_____

_____

SYMPTOM CHECKLISTS:

Please check any of the following symptoms that apply to you, currently or in the recent past:

Physiological Symptoms:

Headaches	□Past	□Present	Dizziness	□Past	□Present
Stomach Trouble	□Past	□Present	Visual Trouble	□Past	□Present
Sleep Trouble	□Past	□Present	Trouble Relaxing	□Past	□Present
Weakness	□Past	□Present	Tension	□Past	□Present
Rapid Heart Rate	□Past	□Present	Difficulty Breathing	□Past	□Present
Intestinal Trouble	□Past	□Present	Hearing Noises	□Past	□Present
Change in Appetite	□Past	□Present	Tiredness	□Past	□Present
Pain	□Past	□Present	Other:_____	□Past	□Present

Have you lost or gained weight recently? If so, how much in how long? _____

How many hours do you typically sleep at night? _____

Quality of sleep: _____

How do you typically feel when you wake up? _____

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Psychological Symptoms:

Stress	□Past	□Present	Unwanted memories	□Past	□Present
Anxiety	□Past	□Present	Shyness	□Past	□Present
Unhappiness	□Past	□Present	Relationship problems	□Past	□Present
Guilt	□Past	□Present	Anger	□Past	□Present
Feel controlled	□Past	□Present	Bad dreams	□Past	□Present
Hopelessness	□Past	□Present	Unwanted Thoughts	□Past	□Present
Inferiority	□Past	□Present	Loss of control	□Past	□Present
Fearful	□Past	□Present	Impulsive behavior	□Past	□Present
Obsessive thoughts	□Past	□Present	Hallucinations	□Past	□Present
Verbal abuse	□Past	□Present	Pregnancy problem	□Past	□Present
Physical abuse	□Past	□Present	Trauma	□Past	□Present
Emotional abuse	□Past	□Present	Indecisiveness	□Past	□Present
Sexual abuse	□Past	□Present	Career issues	□Past	□Present
Temper Issues	□Past	□Present	Work stress	□Past	□Present
Poor concentration	□Past	□Present	Parenting issues	□Past	□Present
Memory problems	□Past	□Present	Sexual problems	□Past	□Present
Nervousness	□Past	□Present	Eating problems	□Past	□Present
Loneliness	□Past	□Present	Legal issues	□Past	□Present
Panic	□Past	□Present	Marital issues	□Past	□Present
Depression	□Past	□Present	Chronic pain	□Past	□Present
Apathy	□Past	□Present	Other:	□Past	□Present
Grief	□Past	□Present	_____		
Compulsive behavior	□Past	□Present			

CURRENT LEVEL OF DISTRESS

Please indicate how stressed you are TODAY. 1 = Not stressed at all, 10 = Extreme distress.

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing suicidal thoughts? _____

Have you experienced suicidal thoughts in the past? _____

Have you ever attempted suicide? If so, please state when and how. _____

Have any of your friends/family attempted suicide? _____