R.A.N Counseling
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Intake form questionnaire

Intake form Questionnaire

Intake

Contact

First Name

Middle Name

Last Name

Preferred Name

Date of Birth (YYYY-MM-DD)

Sex (Select only one)

- [ ] Male
- [ ] Female
- [ ] Intersex
- [ ] X

Gender Identity

Pronoun(s)

Email

Mobile Phone

Email Reminders (Select only one)

- [ ] None
- [ ] 2 hours before appointment
- [ ] 4 hours before appointment
- [ ] 6 hours before appointment
- [ ] 8 hours before appointment
- [ ] 12 hours before appointment
- [ ] 24 hours before appointment
- [ ] 48 hours before appointment
- [ ] 72 hours before appointment
- [ ] 96 hours before appointment

SMS Reminders (Select only one)

- [ ] None
- [ ] 2 hours before appointment
- [ ] 4 hours before appointment
- [ ] 6 hours before appointment
- [ ] 8 hours before appointment
- [ ] 12 hours before appointment
- [ ] 24 hours before appointment
- [ ] 48 hours before appointment
- [ ] 72 hours before appointment

- [ ] 96 hours before appointment

Address

Street Address

City

ZIP/Postal Code

Country (Select only one)

- [x] United States

State (Select only one)

- [x] North Carolina

Emergency Contact

Name

Phone

Email

Street Address

Relationship (Select only one)

- [ ] Dependant
- [ ] Other
- [ ] Parent

- [ ] Spouse
- [ ] Partner
- [ ] Sibling
- [ ] Doctor
- [ ] Lawyer
- [ ] Teacher
- [ ] Third-Party

City

ZIP/Postal Code

Country (Select only one)

- [ ] Canada
- [ ] United States
- [ ] Hong Kong

State (Select only one)

- [ ] Alberta
- [ ] British Columbia
- [ ] Manitoba
- [ ] New Brunswick
- [ ] Newfoundland and Labrador
- [ ] Nova Scotia
- [ ] Northwest Territories
- [ ] Nunavut
- [ ] Ontario
- [ ] Prince Edward Island
- [ ] Quebec
- [ ] Saskatchewan
- [ ] Yukon
- [ ] Alabama
- [ ] Alaska
- [ ] American Samoa
- [ ] Arizona
- [ ] Arkansas
- [ ] California
- [ ] Colorado
- [ ] Connecticut

- [ ] Delaware
- [ ] District of Columbia
- [ ] Florida
- [ ] Georgia
- [ ] Guam
- [ ] Hawaii
- [ ] Idaho
- [ ] Illinois
- [ ] Indiana
- [ ] Iowa
- [ ] Kansas
- [ ] Kentucky
- [ ] Louisiana
- [ ] Maine
- [ ] Maryland
- [ ] Massachusetts
- [ ] Michigan
- [ ] Minnesota
- [ ] Mississippi
- [ ] Missouri
- [ ] Montana
- [ ] Nebraska
- [ ] Nevada
- [ ] New Hampshire
- [ ] New Jersey
- [ ] New Mexico
- [ ] New York
- [ ] North Carolina
- [ ] North Dakota
- [ ] Northern Mariana Islands
- [ ] Ohio
- [ ] Oklahoma
- [ ] Oregon
- [ ] Pennsylvania
- [ ] Puerto Rico
- [ ] Rhode Island
- [ ] South Carolina
- [ ] South Dakota
- [ ] Tennessee
- [ ] Texas
- [ ] Utah

- [ ] Vermont
- [ ] Virgin Islands
- [ ] Virginia
- [ ] Washington
- [ ] West Virginia
- [ ] Wisconsin
- [ ] Wyoming
- [ ] Hong Kong Island
- [ ] Kowloon
- [ ] New Territories

Other

Insurance

Referral

Emergency Contact Person (ECP)

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Current concerns

What brings you to therapy at this time? Is there something specific, such as a particular event? Describe any current problems as you see them.

What are your initial goals for therapy?

Health and Behavioral Health History

Do you work with other healthcare providers currently?

To the best of your knowledge, have you been diagnosed with a mental health condition? If "yes," what is that mental health condition?

Have you worked with a therapist in the past? If yes, what were your reasons for seeking treatment then?

Did you find mental health treatment to be helpful?

Are you currently taking any psychiatric medications?

Have you taken psychiatric medications in the past? If so, please list medication names and approximate time frame and length of time the medication was taken.

Do you have a psychiatrist?

Do you have a primary care physician?

Have you had any prior illnesses, operations, or accidents?

Are you currently taking any non-psychiatric medications?

Please check any of the following that you have experienced in the last 30 days (Select all that apply)

- [ ] Headache
- [ ] High blood pressure
- [ ] Gastritis or esophagitis
- [ ] Hormone-related problems
- [ ] Head injury
- [ ] Angina or chest pain
- [ ] Irritable bowel
- [ ] Chronic pain
- [ ] Loss of consciousness
- [ ] Heart attack
- [ ] Bone or joint problems
- [ ] Seizures
- [ ] Kidney-related issues
- [ ] Chronic fatigue
- [ ] Dizziness
- [ ] Faintness
- [ ] Heart valve problems
- [ ] Urinary tract problems
- [ ] Fibromyalgia
- [ ] Numbness & tingling
- [ ] Shortness of breath
- [ ] Diabetes
- [ ] Hepatitis
- [ ] Asthma
- [ ] Arthritis
- [ ] Thyroid issues
- [ ] HIV/AIDS
- [ ] Cancer
- [ ] amenorrhea/irregular or absence of periods
- [ ] hair loss
- [ ] lanugo
- [ ] Other

Behavioral Health concerns

Do you use recreational drugs? (Select only one)

- [ ] Yes
- [ ] No

Do you drink alcohol? (Select only one)

- [ ] Yes
- [ ] No

Have you ever received substance or alcohol use treatment or detox?

Please check any of the following you have experienced in the past thirty days: (Select all that apply)

- [ ] Increased appetite
- [ ] Decreased appetite
- [ ] Trouble concentrating
- [ ] Difficulty sleeping
- [ ] Excessive sleep
- [ ] Low motivation
- [ ] Isolation from others
- [ ] Fatigue/low energy
- [ ] Low self-esteem
- [ ] Depressed mood
- [ ] Tearful or crying spells
- [ ] Anxiety
- [ ] Fear
- [ ] Hopelessness
- [ ] Panic
- [ ] A Decreased need for sleep
- [ ] Seeing or hearing things other people can't see or hear
- [ ] Purging episodes
- [ ] thoughts of wishing you weren't alive

Are you currently satisfied with your eating patterns? (Select only one)

- [ ] Yes
- [ ] No

Do you ever eat in secret? (Select only one)

- [ ] Yes
- [ ] No

Does your weight generally affect the way you feel about yourself? (Select only one)

- [ ] Yes
- [ ] No

Have any members of your family suffered with an eating disorder that you know of? (Select only one)

- [ ] Yes
- [ ] No

Do you currently suffer with or have you ever suffered in the past with an eating disorder? (Select only one)

- [ ] Yes
- [ ] No

Have you been hospitalized for a psychiatric issue? (Select only one)

- [ ] Yes
- [ ] No

In the past 6 months, have you had suicidal thoughts, thoughts of harming yourself, or thoughts that you no longer wish to be alive? (Select only one)

- [ ] Yes
- [ ] No

Have you ever attempted suicide? (Select only one)

- [ ] Yes
- [ ] No

Have you ever engaged in any self-injury? (for example, cutting or burning yourself)? If so, please explain when this occurred and how many times it happened.

Do you have access to a gun?

Do you have thoughts or urges to harm others? (Select all that apply)

- [ ] Yes
- [ ] No

Have you ever committed an act of violence against someone else?

Is there a family history of suicide attempts that you know of? If so, please elaborate.

Is there a family history of mental illness or substance abuse that you know of? (Select only one)

- [ ] Yes
- [ ] No

Have you experienced or witnessed any event that you deem traumatic that I should know about?

Have you ever been involved in any legal proceedings, including lawsuits or criminal charges?

Social history

What is your current living situation? Do you live alone, with others, family, etc...

If you are in a relationship, please describe the nature of the relationship and months or years together.

Who is part of your support network?

What is your employment status?

What is your level of education? Highest grade/degree and type of degree.

Do you have any religious beliefs that I should know about?

What do you think are some of your strengths or interests?

☐ Agreement & Signature