Anna Lindberg Cedar, MPA, LCSW # 64284
Intake Questionnaire

Welcome to my counseling practice. These questions will help me get a better understanding of the context for our consultation together. Please answer to the best of your ability and let me know if you have any questions about the questions themselves. Feel free to star any areas that are priorities for you or that you would like to discuss more in depth.

Name (Last): **(First):** **(Middle):**

Gender: ______________ Age: _____ DOB: ________________ SSN: _______- ________- ________

Preferred pronoun:___________________________ Sexual orientation:____________________________

Primary Address: ____ City: _______________________ State: _____

Home Phone: (____)____________________Cell Phone: (____)_______________Email: ______________________

Is it OK to leave messages with confidential information on the above voicemail #s? Yes / No

Employment Status: ☐ Not employed ☐ Full-time ☐ Part-time Highest education completed:__________

Employer: ____ Job Title: ______________________________________

Primary Care Physician: ______________________________ Phone #: ______________________________________

Date of your last medical consultation:_________________ Date of last full physical exam:___________________

In case of emergency, contact:

Name: ____________________________ Relationship: ____________________ Phone: ____________________

Primary reasons for seeking counseling now:

____

____

What do you hope to get out of the counseling experience:

____

____

____

Past Experiences with counseling? Yes / No

Dates: ___________ Provider:________________ Dates: ___________ Provider:________________

Dates: ___________ Provider:________________ Dates: ___________ Provider:________________

What did you find **helpfu**l about your past counseling experiences?

____

Was there anything that you **didn't find helpful** or could have been improved?

____

Past/current mental health or substance abuse **diagnoses**:_______________________________________

Are you currently experiencing feelings of **hopelessness** and/or having **suicidal thoughts**? Y/N

If yes, please describe____

History of **suicide attempts**? Y/N Dates: ____

Have you ever taken **psychiatric medication**? Y/N If yes, list medication names, dosage, dates:

____

What is your current **alcohol use**?

Average frequency: ______ x / _____ day/wk/month Avg. quantity on occasion: ____________

Current / past use of **substances** (please circle):

Marijuana:	Current / Past Use	Amphetamines:	Current / Past Use
Opioids:	Current / Past Use	Cocaine or Crack:	Current / Past Use
Hallucinogenics:	Current / Past Use	Non-prescribed Rx:	Current / Past Use
Other: __________	Current / Past Use		

Have you ever experienced **hallucinations** (hearing or seeing things that others could not see or hear?) Y/N

Have you been the victim of **violence or abuse** in your lifetime, either as a child or an adult? Y/N

Have you ever experienced **intimate partner violence**? Y/N Any other **traumatic event**? Y/N

What is your current living situation? Please list the first names, relation, and ages of all of the individuals with whom you live, including roommates, children, and extended family:

____

What are your greatest strengths and resources when confronting stress or adversity?

____

____

Is there anything else you would like for me to know at this time?

____

____