Karoll Counseling, LLC
744 Dulaney Valley Road, Suite 8B, Towson, MD 21204
Phone 443-535-3130 / Fax 410-630-3744

INTAKE QUESTIONNAIRE

Please complete this form as fully as possible. Leave blank any question you would rather not answer, or would prefer to discuss with me. Information you provide here is protected as confidential. I appreciate your cooperation and patience.

PATIENT IDENTIFICATION INFORMATION:

Patient's name: _____ Date: _____

Gender: _____ F ____ M Birth Date: _____ /_____ /_____ Age: _____

Address:_____ City: _____ State: _____ Zip: _____

Phone (home): _____ (cell): _____ May I leave a message? ▫ No ▫ Yes

E-mail: _____ May I email you? ▫ No ▫ Yes

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Who referred you? How did you hear about my services? _____

May I have your permission to thank this person for the referral? ▫ Yes ▫ No

EMERGENCY CONTACT:

Name _____

Relationship to You _____ Phone _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____

_____

PRESENTING PROBLEM(S):

What brings you into treatment/counseling? _____

_____

_____

_____

When did these issues begin? _____

What attempts have been made to deal with symptoms/problem?_____

_____

Why now? _____

_____

What are you hoping to change/What would you like to accomplish in therapy? _____

_____

_____

Prior/Current Diagnoses: _____

MENTAL HEALTH TREATMENT HISTORY:

If you have previously received any type of mental health services (psychotherapy, psychiatric services, etc.) please list name of provider, reason/problems addressed, duration, and reason for termination:

_____

_____

_____

_____

If currently taking any psychotropic medication (antidepressants or others) please list medication name and dose:

_____

_____

Prescribed by: _____

If you are not currently on psychotropic medication but you have in the past, please identify medication and prescriber:

_____

_____

If you have had any hospitalizations or treatment stays (inpatient, residential, PHP, IOP) for psychiatric reasons, (including substance use) please identify reason, name/location and duration of stay:

_____

_____

_____

What was helpful/unhelpful about previous treatment? _____

_____

Please identify family history of psychiatric illness including suicide: _____

_____

GENERAL HEALTH INFORMATION:

How would you rate your current physical health?
Poor ▫ Unsatisfactory ▫ Satisfactory ▫ Good ▫ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc

_____

_____

Do you currently have a primary physician? If yes, who is it_____

Are you currently seeing more than one medical health specialist? If yes, please list:

_____

When was your last physical? _____

Please list any current medication to manage a physical health concern(s): _____

_____

_____

Please list any specific sleep problems you are currently experiencing: _____

_____

Do you participate in a regular exercise routine? ▫ No ▫ Yes If Yes, please describe your routine.

_____

_____

Are you having any difficulty with appetite or eating habits? ▫ No ▫ Yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

FAMILY BACKGROUND AND CHILDHOOD HISTORY:

Were you adopted? ▫ No ▫ Yes Where were you born and raised? _____

Please list your brothers and sisters and their ages:_____

_____

Are your parents married? ▫ No ▫ Yes Divorced? ▫ No ▫ Yes. Widowed? ▫ No ▫ Yes.

If Divorced, How old were you when they divorced ? _____

Who raised you? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

RELATIONSHIPS/CURRENT FAMILY:

Are you currently dating, sexually active, or in a relationship(s)? ▫ No ▫ Yes

How would you identify your sexual orientation: ▫ straight/heterosexual ▫ lesbian/gay/homosexual ▫ bisexual ▫ unsure/questioning ▫ asexual ▫ other:_____
▫ prefer not to answer

Do you have concerns related to your sexual orientation? ▫ No ▫ Yes

Are you currently: ▫ Single ▫ Engaged/Committed ▫ Married ▫ Divorced ▫ Widowed

If dating, engaged, married, separated, divorced, or widowed, for how long? _____

If married/in committed relationship:

Partner's Name: _____ Age: _____

What is your significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

Have you had any prior marriages? ▫ No ▫ Yes How many? _____ How long ?_____

Do you have children? ▫ No ▫ Yes Please list any children with age(s): _____

_____

Do you ( ) rent ( ) own ( ) other: _____ your home?

Who lives in the home with you? _____

_____

Who is your current financial support system? Emotional support system?

_____

_____

Are your loved ones/family supportive of you seeking counseling? specify:

_____

CAREER AND EDUCATION:

Years of education: _____ Currently enrolled in school? ▫ No ▫ Yes

If yes, specify where, for what, part-time, Full-time? _____

_____

Did you attend college? ▫ No ▫ Yes Where? _____

What was your major? _____

What is your highest educational level or degree attained?_____

Academic strengths and struggles: _____

If you are currently employed, who is your currently employer/position? _____

_____

Please list any work-related stressors, if any: _____

_____

Please list significant prior work experiences:_____

_____

List any relevant career and/or educational goals: _____

Indicate any important information about your occupation or career identity:_____

_____

Have you ever served in the military? ▫ No ▫ Yes Describe military service (branch, current military status, special training, rank, time in service, discharge, status, and rank at discharge):

_____

Trauma related to time in service: _____

LEISURE:

Hobbies/Interests? _____

How do you cope with stress/relax? _____

_____

If you use social media (Facebook, Twitter, Snapchat etc.) what sites do you use, and often are you on them?

_____

CULTURAL AND SPIRITUAL:

Are there cultural/ethnic factors that may affect treatment that you want me to be aware of?

_____

Do you receive comfort from spiritual/religious practices? _____

Religious preference? _____

HARM TO SELF OR OTHERS:

Are you at current risk for harm from others or from self? ▫ No ▫ Yes if yes please explain:

_____

_____

Have you ever had suicidal thoughts or attempts? ▫ No ▫ Yes if yes, please explain:

_____

_____

Have you self-harmed /engaged in self-injurious behavior? ▫ No ▫ Yes

If yes, when was the first incident? _____When was the last incident? _____

What methods have you used and where on your body did you injure yourself?

_____

TRAUMA/ABUSE HISTORY

Have you ever experienced a serious traumatic event? ▫ No ▫ Yes

Have you ever felt threatened or bullied? ▫ No ▫ Yes

Witnessed/exposed to domestic violence? ▫ No ▫ Yes

Do you have trauma induced symptoms? ▫ No ▫ Yes, if yes please specify:_____

_____

Have you experienced any of the following: ▫ Physical Abuse ▫ Emotional Abuse ▫ Neglect ▫ Sexual Abuse ▫ Sexual Assault ▫ Unsure ▫ other _____ ▫ None

If yes, and the abuse/neglect occurred in childhood (under 18) was it reported to a Child Protective Services or similar agency? ▫ No ▫ Yes

comments:_____

Have you ever been the perpetrator of abuse? ▫ No ▫ Yes

LEGAL ISSUES:

Current Status
Are you involved in any active cases (traffic, civil, criminal)? ▫ No ▫ Yes

Please describe and indicate the court and hearing/trial dates and charges:

_____

Are you presently on probation or parole? ▫ No ▫ Yes

Past History
Traffic violations: ▫ No ▫ Yes DWI, DUI, etc.: ▫ No ▫ Yes
Criminal involvement: ▫ No ▫ Yes Civil involvement: ▫ No ▫ Yes

If you responded Yes to any of the above described:

_____

SUBSTANCE USE:

If you have used alcohol, please identify date of first use:_____ date of last use: _____

Describe your current use (type of alcohol, avg. quantity per day/week):

_____

If you used recreational drugs, please identify date of first use:_____ date of last use: _____

Describe your current use (substance, route, avg. quantity per day/week):

_____

If you are registered as a medical marijuana patient in Maryland please identify the condition(s) it is being used to treat and current use (type, method avg. quantity per day/week):

_____

If you smoke cigarettes or use other tobacco products please describe current use (method, avg. quantity per day/week):

_____

Behavioral addictions? Gambling, internet, sex, shopping, television, video games, work, other; used in past year?

_____

If there is addictions in your family please describe: _____

_____

ADDITIONAL INFORMATION:

What do you consider to be your strengths?

_____

_____

What do you consider to be your weakness?

_____

_____

Any additional information that would assist us in understanding your concerns or problems:

_____

_____

_____

_____

IF YOU DO NOT HAVE AN EATING DISORDER, YOU ARE NOW DONE WITH THIS QUESTIONNAIRE.

IF YOU DO HAVE AN EATING DISORDER, OR ARE UNSURE WHETHER YOU DO, PLEASE CONTINUE ONTO THE NEXT PAGE.

EATING DISORDER HISTORY:

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How old were you when you first struggled with difficult feelings, thoughts, and/or behaviors about food or weight? _____ years old.

What is the most and least you have weighed since age 13 and when was that?

Lowest weight since age 13: _____ Dates: _____

Highest weight since age 13: _____ Dates: _____

Have you struggled with these feelings, thoughts, and/or behaviors continuously since they began? ▫ No ▫ Yes

If you have had periods of no symptoms since the first onset of your ED, list the start & end dates of each period and what you think enabled you to give up the behaviors and what you think triggered your slip back to them. (If you are unsure of dates, estimate them.)

_____

_____

_____

24 HOUR RECALL:

In the last 24 hours, what did you eat and drink for:

Breakfast_____

Between breakfast and lunch _____

Lunch _____

Between lunch and dinner _____

Dinner_____

After dinner _____

Did you eat or drink anything other than the above (for example, glasses of water, alcoholic beverages, middle of the night)

_____

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FEMALES ONLY:

When was your last menstrual cycle? Month: _____ Year: _____

Are you on birth control/contraceptive medication? ▫ No ▫ Yes If yes, which one? _____

How old were you when you had your first period? _____ Years

CURRENT/MOST RECENT SYMPTOMS:

Check all the behaviors that best describe your CURRENT or MOST RECENT eating disorder symptoms
▫ Restrict food intake
▫ Binge eat
▫ Self-induce vomiting
▫ Feel compelled to exercise
▫ Abuse laxatives
▫ Check body/appearance very often
▫ Try to completely avoid certain foods
▫ Eat in the middle of the night
▫ Chew and then spit out the food
▫ Have food/eating rituals
▫ Diet
▫ Use drugs/alcohol to control appetite
▫ Feeling fat
▫ Think about weight/food a lot
▫ Abuse diuretics

Over the past 28 days, how frequently have you experienced/engaged in these behaviors?

_____

_____

_____

Please describe any other problems you have with food and/or weight. _____

_____

_____

_____
(please use back of paper if needed)