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Intake Questionnaire

For this intake questionnaire either type and bold your answers and email it back to me, or print it out and write and circle your answers and bring it to our meeting. Please complete this questionnaire by our second session together. Feel free to leave items blank if you are not comfortable answering or would rather discuss in person.

Date:_____ Your Name: _____
How did you find me & my practice?_____
Address:_____
Phone: (Cell) _____ (Work)_____
Email:_____
Emergency Contact (EC): (EC--Name) _____
(EC--Phone) _____ (EC--Relationship) _____
Gender: _____ Date of birth: _____ Age_____ Sexual Orientation:_____
Ethnicity: _____
Religious/Spiritual affiliation: _____
Relationship Status: Single In-a-Relationship Married Separated Divorced Widowed Cohabiting
How many children do you have? _____
Occupation: _____
Are you a Lyra client? NO YES If so, which company do you work for? _____
Are you working now? NO YES If yes, is it: Full-time Part-time
Are you going to school now? NO YES If yes, is it: Full-time Part-time
Number of years of education completed: _____ Highest degree you earned in school? _____
Do you have learning disabilities? _____
Do you have any cognitive or neurological impairment?_____
Have you had any serious head injuries? _____
Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy?
YES NO If yes, please describe the # of months or years in therapy and the types you received:
_____
_____
Have you ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties? YES NO If yes, when and why? _____
Have you ever attempted suicide? YES NO If YES, when? _____
Have you thought about committing suicide in the past month? YES NO
If YES, do you have a specific plan for how you would commit suicide? YES NO
Have you ever taken medications for mental or emotional difficulties prescribed by a physician/psychiatrist?
YES NO If yes, what medications were prescribed, when and for what symptoms?
_____
Are you currently using any prescribed medications? YES NO
Please describe:_____
Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities?
YES NO; If yes, please describe: _____
Have you ever had a physical fight with anyone, including your spouse or partner (including throwing things, hitting, shoving, etc.)? YES NO
Have you ever been involved in a lawsuit? YES NO If yes, please describe the circumstances and give dates.
_____
_____
Have you ever been arrested for a crime? YES NO If yes, please describe the circumstances and give dates.
_____
_____

Do you often fear being embarrassed or looking stupid? YES NO

Have you ever had a panic attack where you experienced a sudden rush of anxiety where you felt overwhelmed and it lasted no longer than 10 or 15 mins? (It may have felt like a heart attack, or like you were going to die or loose your mind) YES NO

Have you experienced a traumatic event where you thought you would be physically harmed? (car accident, natural disaster, been the victim of a crime)? YES NO If Y, how much does it interfere with your daily functioning?
_____

Do you currently re-experience this event in flash-backs or dreams? YES NO

Did you ever have sexual contact with someone else that you did not want? YES NO

When in public spaces like a stadium or movie theater, do you have an intense fear about NOT being able to escape because it might be difficult or embarrassing? YES NO

In the last six months have you been excessively preoccupied about a lot of things, like work, school, family, finances, social life, health, and community? Does this interfere with your life? Do you feel you can't control these worries? YES NO

Do you worry that someone is out to get you or physically harm you? YES NO
Do you ever hear voices when no one else is around? YES NO
Do you see shadows or visions around you that others around you would not be able to see? YES NO
Do you ever think that certain things our in the world have special meaning only for you (e.g., like someone's words in T.V. program, an art piece, the way things are oriented together…) YES NO

In the past 30 days, how many days have you drank alcohol? _____How many drinks did you drink on each of these occasions? _____

In the past year, have you smoked any marijuana? Have you used other street drugs (mushrooms, ecstasy, or coke)? YES NO

In the past year, have you gotten hooked on a prescribed medicine or taken more of it than you were supposed to? YES NO

In your life, have you ever regularly used any drugs or medications other than as prescribed? (prescription medications (valium), marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, opiates, ecstasy and others): YES NO

Does your current alcohol or drug use cause any problems in your work, school or relationships? YES NO

In the last month has there been a period of time when you were feeling depressed or down most of the day nearly every day? YES NO Did it last two weeks or longer? YES NO

In the last month have you lost interest or pleasure in almost all of your daily activities? Nearly everyday for two weeks? YES NO

Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number, or checking something several times to make sure that you'd done it right? YES NO

As an adult, have you ever weighed a lot less than you do now? Have others ever thought you were too thin? YES NO

In the past two years, have you ever binged on a lot of food (3000 calories at once)? _____ If yes, have you ever thrown this up? _____

Sleep: On average, how long does it take you to fall asleep? _____. Typically how many minutes are you awake for during the night when you would prefer to be sleeping? _____. How often do you wake up earlier than you would like to and you can't fall back asleep? _____

Which family members do you currently feel supported by? _____
_____
What relationships with family or friends do you currently have where you are not feeling supported? _____
_____
How would you like the social support in your life to be different from how it is today? _____
_____

Describe the frequency, duration and type of any weekly exercise you do: _____
_____

Do you meditate? YES NO
If so, please describe what you do when you meditate and the duration and frequency with which you do it:
_____

Please describe, briefly, the problem(s) that bring you in to see me. What are the symptoms? Intensity? Frequency?
_____
_____

What thoughts do you have on a weekly basis that are distressing to you?_____
_____

What emotions & physical sensations do you have on a weekly basis that you don't like feeling and don't want to have?_____
_____

What do you do to avoid having to think these unwanted thoughts or feel these unwanted feelings? (e.g., distract myself, avoid situations, drink alcohol, chat with friends, get busy with work, exercise, suppress them…)
_____
_____

What are you looking to get out of therapy? What goals do you have for therapy?
_____
_____
_____
_____

For the next items, please circle one number for each rating scale of 1 to 10. The text at each end of each 1 to 10 rating scale indicates the two anchors for that item.

Present Moment
I spend most of my time paying attention to I spend most of my time thinking about

what is happening in the present moment

1 2 3 4 5 6

the past or future

7 8 9 10

I think that negative emotions are OK for me to feel & resisting them maintains/enhances them

1 2 3 4 5 6

I think it's not OK for me to feel angry, sad, afraid or anxious

7 8 9 10

I willingly acknowledge and allow my thoughts and feelings even when I don't like them

1 2 3 4 5 6

I constantly struggle with, push down or avoid my thoughts & feelings

7 8 9 10

Most of my thoughts are not true reflections of reality

1 2 3 4 5 6

If I think a thought, then it must be true

7 8 9 10

I see each of my thoughts as just one of many ways to think about things – what I do next is up to me

1 2 3 4 5 6

My thoughts tell me how things really are, and determine what I do next

7 8 9 10

My thoughts and feelings come and go, but deep down the real me doesn't change

1 2 3 4 5 6

Deep down, my thoughts and feelings are the real me

7 8 9 10

I am clear about what I choose to value in life (what makes me feel alive, thriving & engaged)

1 2 3 4 5 6

I don't know what I am truly enlivened by and what I want from life

7 8 9 10

I work out what I need to do about the things I care about, and I see it through

1 2 3 4 5 6

I don't manage to take small or large action steps on the things I truly care about

7 8 9 10

When I am struggling in life, I am kind and Caring to myself, as this is when I need support the most

1 2 3 4 5 6

When I am having a hard time in life I beat myself up thinking I should be doing better

7 8 9 10

My underlying worth as a person is innate and has been here since I was born

1 2 3 4 5 6

I need to achieve at work & gain approval/love from others to feel I am OK

7 8 9 10

I cannot accept or look at the parts of myself that I think should be better

1 2 3 4 5 6

I face and honor myself and my life exactly how they are today w/o judgment

7 8 9 10

What are some of your strengths? _____

_____

_____

What are a couple of things you really value doing with your time? _____

_____

_____

Is there any other information you think would be helpful for me to know?

_____