INTAKE QUESTIONNAIRE

Nancy L. Hammond, LPC, LLC
4716 Ellsworth Avenue #116
Pittsburgh, PA 15213

All questions contained in this questionnaire are strictly confidential.

Name *(Last, First, M.I.):*		**Today's Date:**
Primary Care Physician:	**PCP Phone #:**	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

How would you describe your overall health currently? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

When was the last time you saw a physician?

What was the reason?

Medical Conditions

Date of Onset	Describe Illness, Diagnosis, Diseases	Treating Physician

Surgeries

Year	Reason	Hospital

Hospitalizations

Year	Reason	Hospital

HEALTH HABITS

Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
	☐ None ☐ Coffee ☐ Tea ☐ Cola		
	# of cups/cans per day?		
Tobacco	Do you use tobacco? ☐ Yes ☐ No		
	Cigarettes – pks. a day	Number of years	Or year quit
Alcohol	Do you drink alcohol? ☐ Yes ☐ No If so, average number of drinks per week		
Drugs	Do you currently use any kind of non-prescription (*illegal*) drugs? ☐ Yes ☐ No		
	If so, name the substance(s) and how often you use.		
	Have you used any kind of non-prescription drugs in the past? ☐ Yes ☐ No		
	If so, name the substance(s) and how often you used.		
	If drug use was in the past, how long have you been sober?		

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FAMILY OF ORIGIN (biological family)				
First Name	**Current Age** (or indicate if deceased & year)	**HEALTH ISSUES**	**QUALITY OF RELATIONSHIP**	(If applicable) **ARE YOU OUT TO THEM?**
Mother _____				☐ Yes ☐ No
Father _____				☐ Yes ☐ No
Siblings _____	M ☐ F ☐ Non-binary ☐ Age _____			☐ Yes ☐ No
_____	M ☐ F ☐ Non-binary ☐ Age ___			☐ Yes ☐ No
_____	M ☐ F ☐ Non-binary ☐ Age _____			☐ Yes ☐ No

Children					
First Name	**Gender** (*M, F, Non-binary*)	**Age**	**Health Issues**	**QUALITY OF RELATIONSHIP**	(*If applicable*) **ARE YOU OUT TO THEM?**
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Primary Support *All those you feel are part of your primary support network*				
Name	**Relationship** (Friend, Family, Coworker, Church Affiliation, etc.)	**Age**	**Frequency of Interaction**	*(If applicable)* Are you out to them?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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Social/Recreational Activities *Activities you currently enjoy/participate in*	
Activity	**How often do you participate in this activity?**

EMPLOYMENT HISTORY			
Age	Job	Length of Employment	Reason for Leaving

How would you rate your current job satisfaction? ☐ Very Satisfied ☐ Satisfied ☐ Unsatisfied

Do you have concerns in this area? ☐ Yes ☐ No

If yes, please explain:

What are your career hopes/goals?

What are your personal hopes/goals?

SEXUAL HEALTH			
Do you participate in unprotected sex?	☐ Always	☐ Sometimes	☐ Never
Do you participate in anonymous/casual sex?	☐ Always	☐ Sometimes	☐ Never
Do you have multiple partners?	☐ Always	☐ Sometimes	☐ Never
Do you use alcohol or other drugs while engaging in sex?	☐ Always	☐ Sometimes	☐ Never

Please use this space to mention anything that was not covered in this form that you think is important for me to know.