



Professional Mental Health Counseling • Health and Wellness Coaching • Ayurvedic Consultations

Heartland Wellness Counseling Health Questionnaire

Today's Date: _____

CLIENT INFORMATION

Last name: _____

First: _____ Middle: _____ Initial: _____

Nick name: _____

Marital status: Single Married Divorced Separated Widow

Social Security no.: _____

Birth date: _____

Age: _____

Gender: Male Female

Street address: _____

Home phone no: _____

Email address: _____

P.O. box: _____

City: _____

State: _____

ZIP Code: _____



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Occupation: _____

Employer: _____

Can we leave a message on your home phone? Yes No

Can we leave a message on other phone? Yes No

If yes, other phone no: _____

REQUESTED SERVICE INFORMATION:

What service(s) is requested at this time?

- Counseling: EAP Individual Couple Group Family
- Evaluation Violence Risk Substance Abuse

We provide face-to-face counseling and distance counseling via phone, email and chat. If you have checked counseling, are you interested in traditional, face-to-face counseling, distance counseling or a combination of both? (Please check appropriate box below.)

- Face-to- face. Distance Face-to-face / Distance Combination

What concern has prompted you to contact a counselor at this time?



Sujatha Reddy
MSEd, BAMS, LPC, DCC



303-325-5617
 ✉ bwellmindbodyspirit@gmail.com
 ● bewellmindbodyspirit.com

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If you are requesting distance services, why are you interested in distance counseling rather than traditional face-to-face counseling at this point?

Please check all that you have experience with:

- Instant Messaging / Chat Encrypted email or chat Email Blogs
- Chat rooms with multiple people Bulletin Boards Payment for items/services online

What type of platform does your computer use?

- Windows Vista. Windows XP. Windows. Mac OS. Linux.

Other: _____

What type of internet access do you have?

- Dial-up Broadband (cable, DSL, satellite)

IN CASE OF EMERGENCY

Who should be contacted in case of emergency? _____

Relationship to client: _____

Home phone no: _____

Work phone no: _____

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Intake / Background information

Have you ever been in treatment with a therapist or counselor in the past? Yes No

If so, when were you treated and for what problem(s)?

What was the result of this treatment?



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Are you being treated by a therapist, counselor, or psychiatrist now?

Are you experiencing any negative feelings or "symptoms" at this time, e.g. feeling anxious, depressed, sad, angry, frustrated, etc?

How severe would you say your symptoms are? Mild Moderate Severe

What have you already tried for this problem?

Have you tried anything that DOES help?

Are you currently taking any psychotropic medication (e.g., anti-depressants or anti-anxiety medication)?

Yes No

If so, what type of doctor prescribed it? Physician Psychiatrist Other

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Have you taken any psychotropic medication in the past? Yes No

Please list all medications you are now taking, including the dosage. Please include prescriptions, over-the-counter, herbal, homeopathic medications and nutritional supplements.

How often do you drink alcoholic beverages? Never Rarely Occasionally Frequently

How often do you use recreational drugs?

Never Rarely Occasionally Frequently Heavily

Please list below all recreational drugs you use, including tobacco.

If you are married or have a "significant other" or long-term partner, how long have you been together? Please describe your relationship.

Do you have any children? Yes No

If so, what are their names and ages?

Name: Age: _____

Name: Age: _____

Name: Age: _____

Name: Age: _____

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Who lives in the household with you?

Name: Relationship: _____

Name: Relationship: _____

Name: Relationship: _____

Do you have any brothers or sisters? Yes No

If so, where are you in the sibling order? Oldest Middle Youngest

Where do your siblings live and how do you get along with them?

Are your parents alive? Yes No

How do you get along with them?

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Do you have in-laws? Yes No

How do you get along with them?

How much education have you completed?

- Some High School | High School Diploma GED Some College College Diploma

If you are a student now, please complete the following 2 questions:

Which school do you attend, how are your grades and how do you like school?

If you are in college or graduate school, what is your major?

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Are you happy with your current job/career? Yes No

If not, why? What jobs/careers have you done in the past and how did you like them?

How many times have you moved in the past year? _____

How is your overall health? _____

Do you have any medical problems now or in the past that would be helpful for me to know about?

Have you ever been arrested or convicted of a crime? Please explain.



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It would be helpful to know about your family of origin, what your childhood was like, and anything else about what your family and life were like when you were growing up. (If your past history includes abuse of any type, please include this.)

Were you ever physically or sexually abused as a child? Yes No

If so, by whom? _____

Is there anything else about you that I should know?

SPIRITUAL HISTORY:

Is spirituality an important resource for you? Yes No

If yes, does your practice of spirituality include:

Attendance at religious services? Yes No Frequency

Practice of spiritual disciplines such as prayer, reading, or meditation? Yes No

Involvement in some type of ministry? Yes No Frequency

Involvement in a small group or with a spiritual director or mentor? Yes No

Adopted from Readyminds with additions to suit my practice.