CTS Comprehensive Therapeutic Services

Comprehensive Family Services PLLC

TextCounseling Intake Form

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CTS TextCounseling Intake Questionnaire

Full Name:		
Address		
Street:		**Apt/Suite:**
Zip Code:	**City:**	**State:**
Date of Birth		
Day:	**Month:**	**Year:**

Gender	☐ Male ☐ Female ☐ GD (Gender Diverse)
Marital/Relationship Status	☐ Married ☐ In a Relationship ☐ Single
Religion	
Currently in Therapy?	☐ Yes ☐ No
Counseling and Therapy History	
How would you rate your current physical health?	☐ Poor ☐ Fair ☐ Good

Have you been diagnosed with physical and/or mental health conditions? ☐ Yes ☐ No If yes to above question, please provide description of diagnosis and treatment status.

Over the past month, how often have you experienced any of the following conditions:			
Feeling nervous, anxious, or on edge	☐ Often	☐ Sometimes	☐ Never
Becoming easily annoyed or irritable	☐ Often	☐ Sometimes	☐ Never
Lack of motivation	☐ Often	☐ Sometimes	☐ Never
Trouble concentrating	☐ Often	☐ Sometimes	☐ Never
Feeling depressed or hopeless	☐ Often	☐ Sometimes	☐ Never
Insomnia	☐ Often	☐ Sometimes	☐ Never
Lack of energy	☐ Often	☐ Sometimes	☐ Never
Poor appetite	☐ Often	☐ Sometimes	☐ Never

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Check off any of the issues below that may affect your mental health:		
☐ Relationship problems	☐ Past Trauma	
☐ Racism	☐ Covid-19	
☐ Current events (news, politics etc.)	☐ Addiction (substance, gambling, etc.)	
☐ Domestic Violence	☐ Loneliness or Isolation	☐ Health Issues
☐ Grief or Loss	☐ Career	☐ Financial Problems
Other (please describe):		

Which or the following populations describe you?		
☐ Veteran or active duty military		
☐ Caregiver of someone living with emotional or physical illness		
☐ LGBTQ+	☐ Student	☐ Trauma survivor
☐ New or expecting parent	☐ Healthcare giver	☐ Person with Disability
☐ Convicted Felon	☐ None of the above	