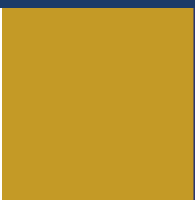




Comprehensive Therapeutic Services

Comprehensive Family Services PLLC

TextCounseling Intake Form





CTS TextCounseling Intake Questionnaire

Full Name:		
Address		
Street:		Apt/Suite:
Zip Code:	City:	State:
Date of Birth		
Day:	Month:	Year:
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> GD (Gender Diverse)	
Marital/Relationship Status	<input type="checkbox"/> Married <input type="checkbox"/> In a Relationship <input type="checkbox"/> Single	
Religion		
Currently in Therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Counseling and Therapy History		
How would you rate your current physical health?	<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> 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	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Becoming easily annoyed or irritable	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Lack of motivation	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Trouble concentrating	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Feeling depressed or hopeless	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Insomnia	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Lack of energy	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Poor appetite	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never



Check off any of the issues below that may affect your mental health:		
<input type="checkbox"/> Relationship problems	<input type="checkbox"/> Past Trauma	
<input type="checkbox"/> Racism	<input type="checkbox"/> Covid-19	
<input type="checkbox"/> Current events (news, politics etc.)	<input type="checkbox"/> Addiction (substance, gambling, etc.)	
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Loneliness or Isolation	<input type="checkbox"/> Health Issues
<input type="checkbox"/> Grief or Loss	<input type="checkbox"/> Career	<input type="checkbox"/> Financial Problems
Other (please describe): 		
Which or the following populations describe you?		
<input type="checkbox"/> Veteran or active duty military		
<input type="checkbox"/> Caregiver of someone living with emotional or physical illness		
<input type="checkbox"/> LGBTQ+	<input type="checkbox"/> Student	<input type="checkbox"/> Trauma survivor
<input type="checkbox"/> New or expecting parent	<input type="checkbox"/> Healthcare giver	<input type="checkbox"/> Person with Disability
<input type="checkbox"/> Convicted Felon	<input type="checkbox"/> None of the above	