Mantis
Counseling and Coaching Services, LLC

Intake Information

Name ____ Date_____________

1. How would you describe your current problem?

2. What caused you to seek services today?

3. What outcome are you seeking?

4. Have you had previous therapy? (Please describe.)

5. Please list any medications or supplements you are taking.

6. Please list any current or previous diagnoses and when and who diagnosed them.

7. Please list your referral source.

Name ____ Date ____________________

Please choose the phrase which best describes your motivation for today's visit:

☐ I don't have a problem, someone else thinks I do.

☐ I do have a problem; I do want to change, and at the same time, I don't want to change.

☐ I am getting ready to change and am about to make that commitment.

☐ I have already begun to take action to resolve this problem.

☐ I have achieved my goal and am focused on preventing relapse.

☐ I have relapsed and am seeking to regain control.

Please use the following code to rate yourself in the past month:

0 = never
1 = rarely
2 = occasionally
3 = frequently
4 = always

_________ 1. Depressed

_________ 2. Stressed

_________ 3. Use alcohol or drugs

_________ 4. Fatigued

_________5. Physical pain

_________ 6. Anxious, worried

_________ 7. Feel shame or guilt

_________8. Satisfied with relationships

_________ 9. Self-directed

_________ 10. In trouble (with law, lover, family member, boss, etc.)

Name ____ Date ____________________

Depression Screen

Rate how often you have experienced these symptoms over the past month:
0 = Never; 1 = Rarely; 2 = Occasionally; 3 = Frequently; 4 = Always

________ 1. Thoughts that you would be better off dead; suicidal thoughts

________ 2. Diminished interest, enthusiasm, and experience of pleasure

________ 3. Feeling depressed or hopeless

________ 4. Trouble falling or staying asleep or can't get out of bed

________ 5. Loss of appetite or excessive appetite

________ 6. View self as worthless, a failure, or shameful

________ 7. Difficulty concentrating

________ 8. Slow movements or speech or agitated movements or speech

________ 9. Belief that you have let yourself or others down

Total Depression Score __________

Interpretation of results:

Less than 6 = Insignificant symptoms
7 – 14 = Mild symptoms
15 – 22 = Moderate symptoms
23 – 30 = moderate/severe symptoms
over 30 = severe symptoms

Name ____ Date ____________________

Anxiety Screen

Rate how often you have experienced these symptoms over the past month:
0 = Never; 1 = Rarely; 2 = Occasionally; 3 = Frequently; 4 = Always

________ 1. Worrying – thinking about things that feel threatening

________ 2. Nausea, headaches, or other symptoms of tension

________ 3. Shortness of breath or rapid heart rate

________ 4. Avoiding places or situations

________ 5. Seeing self as unable to cope

________ 6. Quick to startle

________ 7. Panic or anxiety attacks

________ 8. Restlessness or feelings of anxiety

________ 9. Thinking about negative events that may happen in the future

Total Anxiety Score __________

Interpretation of results:

Less than 6 = Insignificant symptoms
7 – 14 = Mild symptoms
15 – 22 = Moderate symptoms
23 – 30 = moderate/severe symptoms
over 30 = severe symptoms

Name ______________________________________ Date ___________________

Alcohol and Drug Use Screen

How many ounces of alcohol do you consume in a week (please circle estimated amount): 0 – 2 oz. 2 – 6 oz. 6 – 12 oz. 12 – 18 oz. More than 18

Do you use recreational drugs? Yes or No
Explain type, amount, and frequency of use:

____
____
____

Have you ever felt you should CUT down on your drinking? Yes or No

Explain:
____
____
____

Have people ANNOYED you by criticizing your drinking? Yes or No

Explain:
____
____
____

Have you ever felt bad or GUILTY about your drinking? Yes or No

Explain:
____
____
____

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes or No
Explain:
____
____
____

NOTE: Two positive responses to these questions are considered a positive.