UNH Health Services *OFFICE OF HEALTH EDUCATION & PROMOTION*

NAME______________________________ DOB ___/___/___

HR # ___________ (HS Use)

STRESS MANAGEMENT INTAKE QUESTIONNAIRE

IN ORDER FOR YOUR COUNSELOR TO BETTER SERVE YOUR NEEDS, PLEASE TAKE A MOMENT TO ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE. YOUR RESPONSES WILL BE CONFIDENTIAL, AND WILL ONLY BE DISCUSSED BETWEEN YOU AND YOUR COUNSELOR.

Circle any words or phrases that describe how you have been feeling or acting:

Difficulty Concentrating	Overwhelmed
Sad and/or Crying	Alone
Overeating or Not Eating	Isolated
Increased Amounts of Sleep	Feeling like No One Understands You
Decreased Amounts of Sleep	Loss of Appetite
Irritable	Indecisive
Worried	Lazy
Anxious	No Energy/Lethargic
Angry	No Motivation
Racing Thoughts (Your mind going a mile a minute)	Physical Aches or Pains
Argumentative/Fighting	Feeling as Though You Don't Care About Anything
Communication Issues w/Family, Friends or Partners	Misusing Alcohol, Tobacco or Other Drugs
Guilty	Thoughts of Death, Suicide or Harming Someone
Hopeless	Compulsive Thoughts and/or Actions
Worthless	Pessimistic/Negative Outlook

If none of the above words describe how you are feeling, please provide us with some that do:

What stressors or events have you experienced in your life that may have affected you?

Take a moment to reflect upon how you are feeling right now. On a scale of 1 to 10, what number do you identify with? (see scale below) Number:

Think about how you have been feeling over the past two weeks? On the scale of 1 to 10, is there a number that applies to you? Number:

Scale Explanation:

1= *sad, tired, anxious, depressed, withdrawn, irritable, tense, angry*

10=*happy, rested, relaxed, energized, involved with life/academics*

Please remember to complete the other side of the questionnaire.

What is the primary reason for your visit? Are there specific things that you are looking for help with?
(Example: I need help managing my time better …I am having difficulty sleeping …I'm having problems in my relationship)

Is there anything that you currently do, or have done in the past, to help you manage stress? If so, what?

What kinds of activities and past times do you enjoy?

What are your greatest skills or strengths?

Have you ever been treated for any of the following? (Please Circle All That Apply)

Depression	Anxiety (Generalized, Social, Other)	Bipolar Disorder
Panic Disorder	Alcohol and/or Other Drug Concerns	Other ______________

Do you take any medications? If yes, please provide us with their name(s) and purpose.

Please list any questions that you would like your counselor to address during your time together.
(Example: How long will it take to feel better? What should I do on my own to help my wellness? Can my parents find out I'm in counseling?)

Thank you for taking the time to complete this questionnaire.

Please remember to bring this form with you to your first visit.

Reviewed by: _________________________________ Date: ______________

Counselor's Signature