Intake Form

Last Name: (print) _____

First Name: (print) _____Middle Initial: _____

Gender: Male_____ Female_____

DOB: _____/_____/_____ Age: _____

Contact Information:

Address _____
City: _____ State: _____ Zip Code: _____

Telephone: (H) _____ (W) _____ (C)_____
Emergency Phone No. _____
E-mail address: _____

Demographic Data:

Ethnicity: _____
Education (underline one): HS / Trade School / College / Graduate Degree
Occupation: _____
Employed by: _____
How long employed: _____

Name of Physician: _____
Address: _____/_____/_____
(Street) (City) (Zip Code)

Church attending: _____
How long: _____

Referral Information:

Referred by: _____
Address: _____
Telephone: _____
Relationship to you (circle one): Family member, Friend, Pastor, Physician, Other

Current Symptom Checklist:

Directions: Please check the symptom **and** circle the intensity of symptoms you are currently experiencing, **or** have experienced within the last two weeks

Mild (Mi)= Impacts quality of life, but no significant impairment of day-to-day functioning.
Moderate (Mo) = Significant impact on quality of life and/or day-to-day functioning.
Severe (S) = Profound impact on quality of life and/or day-to-day functioning.

[ ] Depressed mood	Mi	Mo	S	[ ] Generally anxious most of day	Mi	Mo	S
[ ] Sleeping problems	Mi	Mo	S	[ ] Excessive worry most of day	Mi	Mo	S
[ ] Eating problems	Mi	Mo	S	[ ] Confused, or jumbled thoughts	Mi	Mo	S
[ ] Elimination problems	Mi	Mo	S	[ ] Frequently agitated	Mi	Mo	S
[ ] Poor concentration	Mi	Mo	S	[ ] Nervous / fearful most of day	Mi	Mo	S
[ ] Mood swings during day	Mi	Mo	S	[ ] Racing thoughts	Mi	Mo	S
[ ] Sad, cry often for no reason	Mi	Mo	S	[ ] Agitation	Mi	Mo	S
[ ] Hopelessness	Mi	Mo	S	[ ] Tight chest, racing heartbeat	Mi	Mo	S
[ ] Guilt / Shame	Mi	Mo	S	[ ] Dizzy / room spinning	Mi	Mo	S
[ ] Fatigue/low energy	Mi	Mo	S	[ ] Light-headedness / Faint	Mi	Mo	S
[ ] Irritability	Mi	Mo	S	[ ] Panic attacks	Mi	Mo	S
[ ] Few friends/social support	Mi	Mo	S	[ ] Chest pain / feels like heart attack	Mi	Mo	S
[ ] Worthlessness	Mi	Mo	S	[ ] Sexual problems	Mi	Mo	S
[ ] Thoughts of death / self-harm	Mi	Mo	S	[ ] Victim of emotional trauma/abuse	Mi	Mo	S
[ ] Ongoing relationship problems	Mi	Mo	S	[ ] Victim of physical trauma/abuse	Mi	Mo	S
[ ] Grief	Mi	Mo	S	[ ] Victim of sexual trauma/abuse	Mi	Mo	S
[ ] Substance abuse	Mi	Mo	S	[ ] Emotionally abusive	Mi	Mo	S
[ ] Health complaints	Mi	Mo	S	[ ] Physically abusive	Mi	Mo	S
[ ] Self-Mutilation	Mi	Mo	S	[ ] Sexually abusive	Mi	Mo	S

[ ] Elevated mood (energetic, feel as though you can do anything)	Mi	Mo	S
[ ] Body movements slow and difficult	Mi	Mo	S
[ ] Phobias (i.e. snakes, heights, elevators, planes)	Mi	Mo	S
[ ] Obsessions (thinking about the same thing over and over)	Mi	Mo	S
[ ] Compulsions / rituals (doing the same things over and over)	Mi	Mo	S
[ ] Binging / purging (eating a lot and throwing up or laxatives)	Mi	Mo	S
[ ] Anorexia (restricting food intake)	Mi	Mo	S
[ ] Aggressive (intimidating, controlling, hurting others, damaging property)	Mi	Mo	S
[ ] Losing or gaining at least 7-10 lbs within a month	Mi	Mo	S

Presenting Problem(s):

Primary Problem: (Main reason you are here today) _____

_____

_____

_____

Secondary Problems: (Other problems that complicate or add to primary problem but are not as serious as the problem above)

1. _____
2. _____
3. _____
4. _____

Previous Outpatient Counseling:

_____ No (If no, please go to next section)
_____ Yes (If yes, please complete questions below)

- How many times have you been to counseling: ___
- Longest treatment: How many sessions _____Beneficial: Y / N
  - Started ____/_____ Ended: ____/_____
  - Therapist name: _____
  - Therapist address: _____
    City:_____Zip Code:_____
    Phone No. _____
- Most recent treatment: How many sessions _____ Beneficial: Y / N
  - Started ____/_____ Ended: ____/_____
  - Therapist name: _____
  - Therapist address: _____
    City: _____Zip Code: _____
    Phone No. _____

Previous Inpatient Treatment (for psychiatric, emotional, or substance abuse):

_____ No (If no, please go to next section)
_____ Yes (If yes, please complete questions below)

- How many times _____
- Longest treatment: Beneficial: Y / N
  - Started ____/_____ Ended: ____/_____
  - Therapist name: _____
  - Therapist address: _____
    City:_____Zip Code:_____
    Phone No. _____
- Most recent treatment: Beneficial: Y / N
  - Started: ____/_____ Ended ____/_____
  - Therapist name: _____
  - Therapist address: _____
    City: _____Zip Code: _____
    Phone No. _____

Current Medication Usage:

_____ No (If no, please skip to next section)
_____ Yes (If yes, please complete questions below)

1. Medication: _____
   Dosage: _____
   Frequency: _____
   Start date: _____/_____
   Reason for taking:: _____
   Side effects: _____
   Beneficial: Y / N

2. Medication: _____
   Dosage: _____
   Frequency: _____
   Start date: _____/_____
   Reason for taking:: _____
   Side effects: _____
   Beneficial: Y / N

3. Medication: _____
   Dosage: _____
   Frequency: _____
   Start date: _____/_____
   Reason for taking: _____
   Side effects: _____
   Beneficial: Y / N

4. Medication: _____
   Dosage: _____
   Frequency: _____
   Start date: _____/_____
   Reason for taking: _____
   Side effects: _____
   Beneficial: Y / N

5. Medication: _____
   Dosage: _____
   Frequency: _____
   Start date: _____/_____
   Reason for taking: _____
   Side effects: _____
   Beneficial: Y / N

Family Emotional / Psychiatric History:

Has any family member had outpatient or inpatient treatment for a psychiatric, emotional, or substance abuse problem?
_____ No (If no, please skip to next section)
_____ Yes (If yes, please complete questions below)

- Who: _____
- Problem: _____
- How long lasted: _____

- Who: _____
- Problem: _____
- How long lasted: _____

Intimate Relationships Background / History

_____ Single
_____ Never Married
_____ Engaged / How Long: _____
_____ Living Together / Date Started: _____/_____ How Long: _____
_____ Married / Date Married: _____/ Months/Yrs. Married: _____
_____ Separated / Date: _____ How Long: _____
_____ Divorced / Date: _____ How Long: _____

Spouse/Significant Other's Name: _____
Spouse / SO's DOB: _____ Age: _____

Previous Marriages/Significant Others:

- 1st Marriage/SO: Years Together: _____. Year Terminated: _____
- 2nd Marriage/SO: Years Together:: _____ Year Terminated: _____
- 3rd Marriage/ SO: Years Together: _____ Year Terminated: _____

Intimate Relationships:

_____ Never been in a serious relationship
_____ Not currently in relationship
_____ Very satisfied with relationship
_____ Currently in serious relationship
_____Satisfied with relationship
_____ Somewhat satisfied with relationship
_____ Dissatisfied with relationship
Very dissatisfied with relationship

Family Background / History: (check blank that applies)

Mother: Living ___Age _____Deceased _____Unknown _____
Separated _____Divorced ___ / No. of marriages: _____
Father: Living: ___ Age _____Deceased _____ Unknown _____
Separated_____Divorced____/ No. of marriages: _____

Siblings:

- Brothers: How Many _____ Ages: _____
- Sisters: How Many: _____ Ages: _____

Your Children:

Name	Age	Gender	Natural	Adopted	Step-child

Persons currently living in your household other than spouse or children: _____
_____

Age you left your family of origin: _____
Reason(s): _____
_____

Describe childhood family experience:

_____ Close family relationships
_____ Overly dependent family relationships
_____ Conflict in family relationships
_____ Distant family relationships
_____ Witnessed physical/verbal/sexual abuse toward others
_____ Experienced physical/verbal/sexual abuse from others

Socio-economic History:

Living Situation: (check one)

___ Living in own home
___ Living in apartment or duplex
___ Dependent on others
___ Dangerous / deteriorating
___ Homeless

Employment: (check one)

___ Employed and satisfied
___ Employed but dissatisfied
___ Unemployed
___ Coworker conflicts
___ Supervisor conflicts
___ Unstable work history
___ Disabled: Reason

Financial Situation:

___ No current problems/stressors
___ Large indebtedness
___ Poverty or below-poverty
___ Impulsive spending
___ Causes relationship conflicts

Social Support System:

___ Supportive family and friends
___ Distant from family of origin
___ Few friends
___ No friends
___ Substance-use-based friends

Legal History:

___ No legal problems at present
___ On parole or probation
___ Arrest(s) no substance-related
___ Arrest(s) substance-related
___ Court ordered this treatment
___ Imprisoned / jailed:
No. of time(s) how long___/_____
Describe last legal difficulty: _____
_____

Military History:

___ Never in military
___ Served in military – no problems
___ Served in military – problems:

Sexual History: (check all that apply)

___ Heterosexual orientation
___ Homosexual orientation
___ Bisexual orientation
___ Currently sexually active
___ Age first sex experience ___
___ Age first pregnancy/fatherhood: ___
___ Promiscuity age from ___ to ___
___ History of unsafe sex: age ___ to ___

SUBSTANCE USE HISTORY:

Family Substance Abuse History:

	Substance(s) Used:
Spouse/Significant other	
Children	
Father	
Mother	
Sibling(s)	
Stepparent / live-in	
Grandparent(s)	
Uncle(s) / Aunt(s)	

Personal Substance Use History

	Age		Status	Frequency	Amount
	First Use	Last Use	C=Currently Using P=Past History T=Trying to Quit		
alcohol			C P T		
amphetamines/speed			C P T		
barbiturates/downers			C P T		
caffeine			C P T		
cocaine			C P T		
crack cocaine			C P T		
hallucinogens (ex. LSD)			C P T		
inhalants (ex. glue, gas)			C P T		
marijuana or hashish			C P T		
nicotine/cigarettes			C P T		
PCP			C P T		
prescription			C P T		
Other			C P T		

Consequences of Substance Abuse: (check all that apply)

__ hangovers __ withdrawal symptoms __ sleep disturbance ___ binges
__ seizures __ medical conditions __ assaults ___ job loss
__ blackouts __ relationship conflicts __ suicidal impulse ___ arrest
__ overdose __ tolerance changes __ loss of control in amount used
__ other: _____

Treatment History:

	Age		Age
__ outpatient	_____	__ 12-step program	_____
__ inpatient	_____	__ Stopped on own	_____
__ other	_____		

Developmental History:

Problems during your mother's pregnancy:

_____ None
_____ She used alcohol
_____ She used drugs
_____ She smoked cigarette
_____ Other / Explain: _____

Emotional or behavior problems during childhood:

_____ alcohol abuse
_____ drug use
_____ pornography
_____ chronic lying
_____ stealing
_____ fire-setting
_____ violent temper
_____ hyperactive
_____ disobedient
_____ lack of attachment
_____ broke things
_____ hostile/angry mood
_____ not trustworthy
_____ immature
_____ indecisive
_____ extreme worrier
_____ impulsive
_____ poor concentration
_____ animal cruelty
_____ self-injurious threats
_____ often sad
_____ fought with others

Social interaction in childhood:

_____ normal social interaction
_____ isolated self/very little interaction
_____ very shy
_____ inappropriate sex play
_____ dominated others
_____ associated with problem kids

Academic / Intellectual Functioning

_____ normal intelligence
_____ high intelligence
_____ learning problems
_____ underachieving
_____ mild retardation
_____ authority conflicts
_____ attention problems

Describe any other developmental problems: _____
_____