Name:_____ Date:_____ Daytime Phone:_____

Intake Information Sheet

Please take the time to fill this out thoroughly as this will help greatly in creating your plan of care. All information is confidential; however there are limits of confidentiality related to reporting of child abuse, elder abuse, and harm to self or others.

Demographics

Race/Ethnicity: ☐ African American ☐ Asian American ☐ Caucasian
☐ Hispanic/Latino/a ☐ Native American ☐ Other (Specify: _____)

Gender: _____

Relationship Status: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Committed Relationship

# of children (if any): _____

Are you currently experiencing any legal problems? ☐ Yes ☐ No
Are you currently experiencing any financial problems? ☐ Yes ☐ No

Symptoms

Please check those below which are a concern for you:

☐ Depression
☐ Racing thoughts
☐ Impulsivity
☐ Memory problems
☐ Anxiety / Panic
☐ Increased talkativeness
☐ Problems in relationships
☐ Chronic Pain/Medical Problems
☐ Social Isolation
☐ Mood swings
☐ Appetite/eating problems
☐ Anger problems
☐ Difficulty sleeping
☐ Compulsive behavior (e.g., frequent hand washing, checking locks)
☐ Work Stress
☐ Problems with Housing

Has there ever been a period of time when you had strange or unusual experiences such as:

Hearing or seeing things that other people didn't notice? ☐ Yes ☐ No
Hear voices or conversations when no one was around? ☐ Yes ☐ No
Visions that no one else saw? ☐ Yes ☐ No
Had the feeling that something odd was going on around you, that people were doing things to test you or antagonize or hurt you so that you felt you had to be on guard constantly? ☐ Yes ☐ No

Please check the box if you have experienced the following life events:

☐ Been a victim of sexual abuse, sexual threats, or received unwanted sexual attention
☐ Been intentionally hurt physically or threatened by someone you know
☐ NON-military experiences with violent crime, severe accidents, natural disasters, or other traumas
☐ Experiences during military service that were extremely frightening, horrifying or upsetting
☐ I prefer not to respond here (If checked, please move on to the substance abuse section).

Did any of these experiences occur before the age of 18? ☐ Yes ☐ No
Are you currently troubled by memories from these experiences? ☐ Yes ☐ No

Substance Use

How often did you have a drink containing alcohol in the past year?
☐ Never ☐ Once a month or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week

Typical type of alcohol consumed: ☐ Beer ☐ Liquor ☐ Wine ☐ Other: _____

Average number of drinks when drinking: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often did you have six or more drinks on one occasion in the past year?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Recreational drug use? ☐ Yes ☐ No If yes, what drugs: _____
Cigarette smoker? ☐ Yes ☐ No How many years? _____ Number of cigarettes per day: _____
Caffeine use? ☐ Yes ☐ No If yes, how much per day? _____

(please continue on the back side of this page)

Name:_____ Date:_____ Daytime Phone:_____

Mental Health Treatment History

Any history of mental health treatment (e.g., counseling or medication)? ☐ Yes ☐ No

If Yes, when and for what reason: _____

_____

_____

Ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, when and where were you treated?_____

What medications (if any) have you been prescribed for mood (e.g., anxiety, depression) or sleep in the past? Please provide doses if you know them: _____

_____

_____

Please list any prior or current mental health diagnoses:_____

_____

Medical History

Having difficulty managing any medical problems? ☐ Yes ☐ No -- Please describe: _____

Please check any problems you are having presently or have had in the past:

☐ Brain injury ☐ Stroke ☐ Heart condition ☐ High blood pressure ☐ Diabetes

☐ Cancer ☐ Chronic pain ☐ Thyroid problems ☐ Neurological disease (Alzheimer's, Parkinson's, etc.)

Do you have a family history of mental health diagnoses (depression, bipolar disorder, schizophrenia, etc.)? ☐ Yes ☐ No

Military Service

Branch of Military:_____ Dates of Service:_____

Highest Rank: _____ Primary Duties: _____

Combat: ☐ None ☐ WWII ☐ Vietnam ☐ Korea

☐ Gulf War I ☐ OEF/OIF ☐ Bosnia ☐ Other: _____

Current Problem/Concern

Are you **currently** receiving psychotherapy from any other organization or clinician at this time? ☐ Yes ☐ No

Given the issues identified, what are the primary concerns for which you are seeking treatment?

_____

How long have you had these problems?_____

Had these problems before? ☐ Yes ☐ No Any significant event triggering these problems? ☐ Yes ☐ No

What solutions to these problems have been most helpful to this point?

☐ Family/social support ☐ Keeping busy/distracted ☐ Exercise ☐ Alcohol/substance use

☐ Spirituality/religion ☐ Counseling ☐ Medication ☐ Other: _____

In your words, what are your goals for treatment:

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

6.) _____