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CLIENT INTAKE

Complete this questionnaire as candidly as possible and write legibly. The information you provide here is protected and confidential. It will help us in our work together. Bring this form to your first session or if you wish, you can email or fax it before we meet.

Demographic Information

Today's date:		**How were you referred?**	
Full name:		**Social security no**:	
Gender:	**Ethnicity:**	**Sexual orientation**:	
Age:	**Birthdate:**	**Place of birth:**	
Relationship status:	**Years together:**	**Spiritual affiliation:**	**Are you observant? Y or N**
Number of times married?		**Highest degree earned & Area of study:**	
Employment status:		**Occupation & Employer:**	
Year relocated to the area:		**Year came to US:**	**From where?**

Contact Information: May a message be left?

Address: _____ **Y or N**
Phone/Text: _____ **Y or N**
Email: _____ **Y or N**
***texts and emails are not considered a confidential form of communication**

Emergency Contact: Name, Phone & Relationship to the Individual

Living Situation

Provide the names, ages, occupations (or grades) for the individuals you live with. Also, include this information for any significant other or children not living at home and note the frequency of contact. Identify pets in the home by kind, breed, age and sex. Note any concerns.

Reason for Seeking Treatment

For each issue, problem or concern, note: when it started, the event that made it surface (if any), the ways in which it impacts you now and identify the overall level of severity: low, moderate, severe or very severe. Also, since the issue started, do you feel better, worse or the same? By how much on a scale from 0 to 100%?

Social History

What concerns do you have about your present day close relationships (e.g., marital, romantic or friends)?

What concerns do you have in your relationships with your children, parents, siblings or extended family?

Health & Medical History

1. How do you see your health?

Note the date of your last physical exam or annual check-up and the outcome.

2. Have you experienced any of the following?

__serious or chronic illnesses or diseases	__chronic conditions or disorders	__chronic pain
__serious physical injuries or head trauma	__hormonal imbalances	__irregular menstrual cycles
__loss of consciousness	__seizures	__other: _____
__miscarriage or abortion	__oxygen deprivation	__none

For each, note: the health issue, date of diagnosis, treatment received, prognosis and whether or not the condition is controlled now.

3. For your health care, do you use?

__traditional medicine __alternative medicine __complementary medicine __other: _____

4. Identify all practitioners from whom you receive care at this time, including your primary care practitioner and psychiatrist.
Note the provider's and clinic's name, address and telephone number and the reason for seeking treatment.

5. Would you like me to coordinate care with any of your providers? Y or N
If yes, identify the provider.

6. Do you take?

__prescriptions __over the counter remedies __dietary supplements __other: _____ __none

For each, indicate: dosage, frequency, substance name, reason taken, period of time taken, effectiveness and any side-effects.

7. What kinds of exercises or physical activities do you typically do?

For each, indicate: the duration and frequency you engage in these activities on average.

Family & Developmental History

1. What medical illnesses run in your family?

2. Is there a family history of any of the following (diagnosed or undiagnosed) conditions?

__substance abuse	__learning disability	__mental illness (e.g., anxiety, depression, bipolar or psychotic disorder)
__suicide or attempt	__compulsive or addictive activity	__cutting, burning or other similar behavior
__violence	__psychiatric medication	__psychiatric hospitalization
__arrests	__domestic violence	__sexual, physical or emotional abuse, neglect or other trauma
__legal issues	__eating disorders	__other: _____
__therapy	__reckless or impulsive behavior	__none

3. Have you experienced any unusual or traumatic events or witnessed any unusual or traumatic incidents against others or animals?

__physical abuse or domestic violence	__emotional abuse or neglect	__other: _____
__extreme event exposure (e.g., crime, accident)	__sexual abuse or unwanted sexual experiences	__none

4. Have you experienced or suspected any of the following during your school years?

__learning or intellectual disabilities	__ADHD	__autism	__communication or tic disorder
__emotional problems	__bullying	__being bullied	__grade retention, suspension or expulsions
__stealing from others or vandalism	__failing grades	__hyper-focus	__aggression at property, others or animals
__gifted or accelerated class placement	__shyness	__special education	__sexual acting out
__verbal outbursts	__fire-setting	__using weapons	__other: _____
__truancy	__running away	__home-removal	__none

5. As far as you know, were there any complications in utero or reaching your developmental milestones (e.g., bed wetting)? Y or N
If yes, explain:

Mental Health History

1. Have you experienced any of the following?

__individual therapy __couple therapy __group therapy __psych hospitalization __other: _____
__workshops/retreats __coaching __mind-body or energy work __day treatment program __none

For each, note: the activity, reason, session length and frequency, start date, stop date (or indicate on-going) and effectiveness.

2. Excluding the current medications taken (if any), do you have a history of psychiatric prescription in the past? Y or N
For each, indicate: dosage, frequency, medication, reason taken, start and stop dates and the basis for discontinuance.

3. Have you experienced or engaged in the following?

__suicidal thoughts __suicide attempt __self-mutilation (e.g., burn, cut, pick, etc.) __aggression at property, others or animals
__unwanted thoughts __repetitive acts __ritual counting or checking __changes in sexual behavior or interest
__hoarding __over-cleaning __uncontrolled tapping or other movement __unrestrained gambling or other behavior
__lavish spending __reckless driving __excessive online or gaming activity __other: _____
__excessive activity __impulsive acts __excessive hand washing or showering __none

4. Have you experienced any of the following?

__smelled unusual odors that others couldn't __seen images others couldn't __heard voices others couldn't
__had sensations or body symptoms that didn't make sense __tasted things others couldn't __thoughts put in or taken away
__felt others were talking, following or out to get you __special powers __other: _____
__received or sent unspoken messages __thought control __none

5. With regard to your eating habits or weight maintenance practices have you engaged in or experienced any of the following?

__vomiting __fasting __laxative use __eating a lot at once __shame or guilt about eating
__restriction __diuretic use __extra exercise __significant weight change __other: _____
__diet pills __drug use __enemas __extreme worry over weight gain __none

6. Have you experienced any of the following?

__losing big chunks of time __feeling out of body __flashbacks __trying to block out or forget distressing events
__upsetting nightmares __becoming easily startled __feeling dazed __other: _____
__hyper-alertness __self-blame for trauma __feeling dreamy __none

7. Have you experienced any of the following for a period of a few days or more?

__a high or irritable mood __increased activity or energy __inflated self-esteem or grandiosity
__feeling well-rested on little sleep __being more talkative than usual __racing thoughts
__increased goal-directed activity __distractibility __increased sexual activity
__engaging in reckless behavior __increased restlessness __other: _____
__impulsivity __feeling powerful __none

8. Have you experienced any of the following?

__anxiety __panic attack __trembling or shaking __racing heart __worry that is difficult to stop
__sweating __shortness of breath __choking __chest pains __sudden fear of going crazy or dying
__chills __light-headedness __abdominal distress __blank mind __feeling keyed up or restless
__fatigue __numbness __panic at night __nausea __other: _____
__faintness __fear to leave the house __fear of losing control __racing thoughts __none:

9. Have you experienced any of the following for a persistent period of time of more than a few days?

__depressed, sad, empty or hopeless mood __sluggishness __fatigue or low energy
__loss of interest or pleasure in life activities __concentration difficulty __thoughts of death or suicide
__too much or too little sleep __worthlessness __low self-esteem
__weight loss or gain __restlessness __irritability or agitation
__decreased sexual desire __indecisiveness __other: _____
__mood swings in general or before menses __guilt or shame __none

10. Check all that currently describe you:

__I feel used and taken advantage of by others a lot.
__People sometimes call me arrogant.
__It's all or nothing. No in between for me.
__Right is always right and wrong is always wrong.
__I often feel attacked by others.
__I like to be the center of attention.
__I am uncomfortable in many social situations.
__I generally prefer solitary activities.
__I don't care if I am liked.
__My life goals or self-worth can change quickly.
__People think my emotions change fast.
__I feel closer to others than they do to me.
__Rules are for other people.
__I fear ridicule from those close to me.
__I have difficulty in starting or ending a project on my own.
__People say I get angry easily or that my response is more intense than needed.
__I tend to get close to others fast and then get disappointed.
__I neither desire nor enjoy close relationships.
__I don't always know what I want or need or how to ask for it.
__I fear disapproval and rejection.
__I usually question the motives or loyalty of others.
__I generally don't trust others.
__I tend to be perfectionistic or like things done a certain way.
__People see me as a stickler for details and rules.
__I am alone a lot of the time, but I want to be with others.
__I am special or different from others.
__I often feel that people don't treat me the way I deserve.
__I feel inadequate around others.
__I have difficulty with everyday decisions and seek out help alot.
__I find it difficult to understand what others feel.

Substance Use History

1. What substances have you tried or used?

__alcohol __caffeine __marijuana __hallucinogens __inhalants __opioids __prescription abuse
__sedatives __amphetamines __cocaine __stimulants __tobacco __diet pills __other: _____

For each, note: substance, average amount taken and average frequency, age started and how long ago the last usage was. Also, note whether or not the usage continues (e.g., caffeine-tea, average 2 cups on a daily basis, started at age 10, last used today, on-going).

2. Have you experienced any of the following as a result of substance use:

__hangovers __binges __blackouts __injury __relationship conflicts
__overdose __arrests or DUI __assaults __sleep issues __withdrawal symptoms
__tolerance changes __self-harm __bad thoughts __increased use __medical or physical conditions
__job or school problems __risky behavior __cravings __cutting down __other: _____
__medical attention __accidents __loss of control __seizures __none

3. Have you or others close to you had concerns about your substance usage? Y or N
If yes, explain:

4. Have you participated in any substance abuse treatment including a 12-step program? Y or N
Identify: the type of program, clinic name, start date and stop date (or indicate on-going) and session length and frequency.

Employment & Legal History

1. Do you have any concerns related to your work situation or career or have you in the past?

__job or assignment changes __layoff or termination __relationships at work __other: _____
__schedule or commute __job stress or burnout __disciplinary actions __none:

2. Have you served in the military? Y or N
Indicate: branch, service start and end date, position, discharge rank, any combat or trauma exposure or service-related disability.

3. Do you have any financial concerns or have you in the past? Y or N
If yes, describe:

4. Do you have any pending or current legal issues or have you in the past?

__disability claims __ divorce or custody issues __arrests __ other: _____
__bankruptcy or evictions __ social service intervention __civils suits __none

Life Tools

1. What activities, practices, interests, hobbies or relationships have brought the most joy or meaning to your life?

2. What do you or others see as your strengths?

3. What inspires you?

4. What are your most important values? Asterisk the one(s) you want to live out more fully.

5. What is the hardest thing you have had to overcome and what got you through it?

6. What are your deepest or most important dreams and aspirations?

7. What dreams or parts of yourself have you given up on?

8. What major fears or concerns about yourself or life in general do you have?

9. If you continue your present path, what regrets do you think you will have when you reach age 100? (Do <u>not</u> include regrets from the past. Only include things you will regret if you continue as you are right now. Tip: Complete the statement, "I wish I had…").

10. Is there anything else that you think is important for me to know about you or our work together?