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NEW CLIENT INTAKE

DO NOT WRITE IN THIS SECTION FOR STAFF USE ONLY!
(Provider comment on all pertinent issues, develop by interview any additional history and record significant findings here.)

Additional Demographic Information Relevant to Treatment:

S:*(history of present problem & circumstances, e.g. Type, Duration, Frequency, Intensity & Severity of Emotions &/or Behaviors on 0-10 scale, with 0 being no problem and 10 being the worst ever, SIGECAPS, manic, depressive, psychotic, anxiety dissociative, eating disorder symptoms, etc.)*

Demographic Information: (please print clearly)
Date: _____ Name: _____ Birth Date: _____Age: _____ Sex: M/F
Job/Occupation: _____ SSN: _____
Address:_____ City:_____ State:____ Zip:_____
Home Phone: _____ May I leave a message? Yes/No
Cell Phone: _____ May I leave a message? Yes/No
Work Phone: _____ May I leave a message? Yes/No
E-mail Address: _____ May I e-mail you? Yes/No
Spouse/Partner's Name: _____
In case of emergency notify (local): _____ Relationship: _____
Phone numbers: (Home) _____ (Cell) _____ (Work) _____

Insurance Co: _____ Policyholder:_____ DOB: _____
Subscriber #:_____ Group #:_____ Copay:_____

Primary Care Physician: _____ Phone: _____
If you do not have a Primary Care Physician, would you like a referral? Yes/No

Church Affiliation (if any): _____ Pastor:_____
Referral Source (How did you find out about us?) _____

Employer & Address: (we will not contact your employer without written permission)

_____

Primary Concern:
Briefly, what are the problems or concerns that brought you here today?
_____
_____
_____
_____

S-
I-
G-
E-
C-
A-
P-
S-

What do you consider to be the top three stresses in your life?

1. _____
2. _____
3. _____

How upsetting are these problems to you? (Circle one) Mild Moderate Severe

Mood
Your mood over the last two weeks would best be described as: (Circle those that apply) Calm Happy Sad Anxious Angry Frustrated Worried Hopeless Helpless
Other:_____

Past Mental Health History: *(Previous Psychiatric/Substance Abuse Treatment Inpatient, Outpatient, AA, Family Violence, etc. Include kind of problem, dates, treatment type, length, and who they saw.)*

Neurovegetative & Behavioral Symptoms:
Circle the items below that have been a problem for you in the last month:

Sleep	Enjoying Life	Motivation	Fatigue Guilt	Poor Concentration
Appetite Change		Impulsiveness	Loss of Sex Drive	Racing Thoughts
Over Talkativeness		Poor Judgment	Strange Thoughts or Behavior	
Periods of Very High Energy			Periods of Very Low Energy	

Family Mental Health History: *(Family Psychiatric/Substance Abuse History)*

Mental Health History
1. Have you been in counseling or mental health treatment before? (i.e. Counselor, Psychiatrist, Psychologist, Marriage or Family Counselor, or Pastor). Yes/No
2. Have you ever been hospitalized for mental or emotional problems? (For example: nervous breakdown, depression, suicide, mania, schizophrenia, anxiety, drug or alcohol problems, etc) Yes/No
3. Has anyone in your family had mental or emotional problems? (e.g. nervous breakdown, depression, suicide, mania, drug or alcohol problems, etc) Yes/No

RISK ASSESSMENT (Circle your response to the following questions)

1. Have you ever been so distressed that you wished to end your life? Yes/No
2. Have you done anything to hurt yourself or attempt to end your life? Yes/No
3. Have you ever heard voices telling you to hurt yourself? Yes/No
4. Have you had family members who attempted or committed suicide? Yes/No
5. Are you currently so distressed that you wish to end your life? Yes/No
6. Are you thinking of killing or hurting yourself right now? Yes/No
7. Do you have a specific plan to hurt yourself? Yes/No
8. Do you have access to any weapons/means to hurt yourself? Yes/No
9. Have you done anything to harm yourself recently? Yes/No
10. Are you currently hearing voices telling you to hurt yourself? Yes/No
11. Have you had thoughts during the last week of killing or hurting yourself? Yes/No
12. Have you ever hurt anyone or destroyed property on purpose? Yes/No
13. Have you ever had thoughts of killing or hurting someone? Yes/No
14. Have you attempted to hurt anyone or destroyed property on purpose? Yes/No
15. Have you ever been arrested for violent behavior? Yes/No
16. Have you ever heard voices telling you to hurt others? Yes/No
17. In the past year, have you slapped, kicked, punched or hurt anyone? Yes/No

Physical Symptoms

Circle any physical symptoms listed below that were a problem for you in the last month:

Headaches	Dizziness	Heart Pounding	Muscle Spasms
Muscle Tension	Sexual Problems	Diarrhea	Vision Changes
Numbness	Tics/Twitches	Fatigue Fainting	Blackouts
Chest Pains	Skin Problems	Nausea	Chills/Hot Flashes
Sweating	Rapid Heart Beat	Choking Sensations	Stomach Aches
Shortness of Breath	Trembling/Shaking	Muscle/Joint Pain	

Answer if Female:

Are you, or is there a chance you might be pregnant? Yes/No

When was your last normal menstrual period?_____

Medical History

1. As a child, did you have any illnesses, medical problems, or head trauma? Yes/No
   Please tell us about these: _____

_____

2. As an adult, have you ever any illnesses, medical problems, or head trauma? Yes/No
   Please tell us about these: _____

_____

3. Do you have any current illnesses or medical problems? Yes/No
   Please list these on the back of this form.
4. Are you allergic to any medications or foods? Yes/No
5. Do you have any physical limitations/barriers? Yes/No
   if yes, please list: _____
6. Please **list any medication** and dosage you are currently taking or have taken within the last year (include over the counter medication, aspirin or laxatives and herbal remedies).

a. d.

b. e.

c. f.

Alcohol Use

1. Have you had trouble with alcohol in the past? Yes/No
2. Do you currently drink alcoholic beverages? Yes/No

If **YES**:

1. What is your drink of choice?_____
2. Have you ever felt you should cut down on your drinking? Yes/No
3. Have people annoyed you by criticizing your drinking? Yes/No
4. Have you ever felt bad or guilty about your drinking? Yes/No
5. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (e.g. eye opener)? Yes/No

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Risk: *(Assess suicidal/homicidal intent, plans, hx of attempts, self-mutilation & most violent thing ever.)*

Physical Symptoms:

Past Medical/Surgical History: *(Include kind of problem, dates, treatment type & length, and provider seen)*

Allergies:

Current Medications: ***(name, dose, dates & for what)***

Substance Abuse Hx: *(As appropriate, include hx of problems, amount, route, age of onset, duration/pattern, tolerance, withdrawal, hx of blackouts, consequences & last use for alcohol, illicit, prescription, caffeine, etc.)*

CAGE: __ out of 4

Social History

1. Number of brothers___ & sisters:___Where are you in this order(1,2,etc.) ____
2. Are your parents divorced? Yes/No
   If yes, how old were you when they divorced?
3. What was your childhood like?

Do you feel that childhood events contribute to your current problems? Yes/No

What is Your Marital Status: Single Married Divorced Widowed Separated
Number of Years Married: _____Total Number of Marriages: _____
Do you have any children? Yes/No If yes, what are their ages? _____

Current Family:

How satisfied are you with your current family life? (circle one)
Very Unsatisfied Unsatisfied Satisfied Very Satisfied

Social Support

How satisfied are you with the support you receive from your family/friends?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied

Have your current difficulties affected your family/friends/coworkers? Yes/No

Developmental History

1. Were you a normal delivery? Yes/No
2. Did you walk and talk at the same time as your same age peers? Yes/No
3. Any memories of abuse? Yes/No
   If yes, are those memories bothering you now? Yes/No

Have you ever experienced any traumatic events or losses in your life?

_____

_____

_____

Education History

1. How many years of education have you completed?_____
2. What degrees do you have?_____
3. Were you held back or did you fail any grades? Yes/No
   If yes, which grades?_____
4. Were you ever suspended in school? Yes/No
   If yes, how many times?_____
5. Did you get into physical fights in school? Yes/No
   If yes, how many fights?_____
6. While going through school, did you ever have any interactions with the law? Yes/No
7. Did you receive any special education? Yes/No
8. Is English your primary language? Yes/No
9. Do you have any difficulty reading or writing? Yes/No
10. Do you need a language interpreter? Yes/No

Job History

1. How many jobs have you held? _____
2. How many jobs have you been fired from? _____
3. How satisfied are you with your current occupation?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied
4. Do you have problems with your work performance or boss? Yes/No

Habits:.

1.Do you smoke or use smokeless tobacco? Yes/No
   If yes, how much? _____ Would you like to quit? Yes/No
2. Do you consume caffeinated drinks? Yes/No If so, how much? _____
3. Do you exercise? Yes/No If yes, how many days per week?_____
4. Do you have problems with gambling? Yes/No

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Psychosocial History/Issues Warranting Further Attention:*(abuse, childhood, developmental, marital, family, occupational, military, housing, spirituality, educational, support & leisure, nutritional concerns, etc.*)
(Initial family genogram on back ⇒)

Quality Of Life: What do you do for leisure?

Do you have difficulties pursuing leisure/recreational activities? Yes/No

How satisfied are you with your quality of life?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied

Spirituality: What does spirituality mean to you?

_____

Do current difficulties affect your spirituality? Yes/No

Nutrition:
Are you on a special diet? Yes/No
Do you purge, restrict, or overeat? Yes/No
Do you have any difficulties or concerns related to food intake? Yes/No

Sexuality: Are you satisfied with your sex life? Yes/No

Pain: Do you have problems with pain? Yes/No If yes: Mild Moderate Severe (Circle)

Goals For Treatment
What are your goals for treatment? In other words, what things would you like to see change or be different?
1. _____
2. _____
3. _____

Are you motivated to learn new ways to deal with your problems? Yes / No

Previous Counseling or Chemical Dependence Services
Have you ever seen anyone or are you currently seeing anyone for:
Individual Therapy Y/N Marital Therapy Y/N Group Therapy Y/N

Name	Month/Year	Length	Reason	Helpful? Y/N

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COMPREHENSION ABILITY
Reads/Understands English? Yes/No
Understands written instructions? Yes/No
Understands Verbal Instructions? Yes/No
Responds Appropriately? Yes/No

O: Mental Status Exam:
Oriented by:( )Person, ( )Place, ( ) Situation, ( )Time
Appearance: Alert, Well-groomed, Unkempt, Disheveled, Tearful, Looks: Stated age, Older, Younger
Behavior: cooperative, open, evasive, reserved, cautious, Defensive, Awkward, Restless, Agitated
Mood:

Affect: Full Range, Appropriate, Subdued, Blunted, Constricted, Labile, Other:
Eye Contact: Intense, Good, Appropriate, Moderate, Poor, None
Speech: WNL, Talkative, Rapid, Slow, Stuttering,
Loud, Soft, Rambling, Slurred, Pressured, Other:
Thought Process: Normal flow, Loosening of Associations, Disorganized, Suspicious, Racing, Circumstantial, Tangential, Incoherent
Thought Content: WNL, Delusions, Helplessness, Hopelessness, Worthlessness, Other:
Perceptions: WNL, Auditory/Visual/Tactile/ Olfactory Hallucinations, Illusions, Other:
Memory: WNL, 3 objects: Yes/No, Serial 7s: Yes/No
Judgment: Intact Fair Impaired Poor
Insight: Good Fair Poor None

Psychological Tests/Rating Scale/Lab Results: