

CLINICAL INTAKE FORM

Name _____ Date _____

DOB _____ Race(optional) _____ Social Security # _____

Who may we thank for this referral? _____

What would you like therapy to help you change? _____

PRIMARY RELATIONSHIPS (Current or past)

Currently married Y N How long? _____ Living with spouse? Y N
 In committed relationship Y N How long? _____ Living with partner? Y N
 Have you been divorced? Y N When? _____
 Have you been widowed? Y N When? _____
 Have you ended a committed relationship? Y N When? _____

Name of spouse/partner _____

CHILDREN (include stepchildren)

First name	Age	Year in school/occupation	Living with you now?
_____			Y N
_____			Y N
_____			Y N
_____			Y N

FAMILY HISTORY (Please circle as appropriate: Y=Yes, N= No, U=Unknown)

Were you raised with both biological parents Y N if no, by whom? _____
 Were your parents divorced/separated? Y N if yes, how old were you? _____
 What # child were you in your family of origin? _____ Of how many children? _____
 Were you raised with step siblings/half siblings? Y N

Did you *observe abuse of* any family member in your family of origin? Y N U

Were you abused/neglected in your family of origin? Y N U

Outside your family of origin, have you experienced abuse? Y N U

Circle type of abuse: sexual abuse physical abuse emotional abuse harassment

Have you experienced the loss by death of a:

Parent? Y N If yes, whom? _____ Date: _____

Other family member? Y N If yes, whom? _____ Date: _____

Close friend? Y N If yes, whom? _____ Date: _____

Have your mother, father or siblings experienced any of the following problems?

- Alcohol or drug abuse? Y N U if so whom? _____
- Significant depression? Y N U if so whom? _____
- Suicide attempts? Y N U if so whom? _____
- Significant anxiety? Y N U if so whom? _____
- Mental illness? Y N U if so whom? _____
- Hospitalization for
 - Emotional problems? Y N U if so whom? _____
 - Chronic physical illness? Y N U if so whom? _____
 - Incarceration (jail/prison)? Y N U if so whom? _____
 - Anger Problems? Y N U if so whom? _____

CURRENT USE OF ALCOHOL OR DRUGS

About how many drinks do you consume in a week? _____

- In the last year, have you used any mood enhancing prescription drugs? Y N
- Picked up or charged with a drug related offense? Y N if yes, what? _____
- Lost time from school or work because of use? Y N U
- Experienced a medical problem because of use? Y N U
- Been fired from a job because of its use and effects? Y N U
- Felt you ought to cut down on your alcohol/drug use? Y N U
- Had people annoy you by criticizing your alcohol/drug use? Y N U
- Felt bad or guilty about alcohol/drug use? Y N U
- Had a drink or used drugs as an eye opener first thing in the Morning to steady your nerves, get rid of a hangover, or to Get the day started? Y N U

My average daily nicotine use is: _____

My average daily caffeine use is: _____

Current medical care

Physician: _____

Medical diagnosis: _____

Medications/Dosage: _____

What type of exercise do you get? _____ Frequency _____

PAST MENTAL HEALTH/CHEMICAL DEPENDENCY TREATMENT (Include outpatient treatments and hospitalizations)

<u>Dates (Month/Year)</u>	<u>Where</u>	<u>Primary therapist</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

STRESSORS

Are you experiencing *significant changes, loss, or difficulties* in the following areas?

- Financial Y N U
- Primary relationship (family/friends) Y N U
- Housing Y N U
- Physical health of self or family member Y N U
- Access to health care Y N U
- Occupational/employment Y N U
- Legal Y N U
- Education Y N U
- Other _____

EDUCATION

Have many years of schooling have you completed? _____

Do you hold any degrees or diplomas and if so, which? _____

Do you now, or have you ever had a learning disability? Y N U

If so, what was the disability? _____

EMPLOYMENT

Are you currently employed? Y N Occupation/employer _____

Are you satisfied with your present job? Y N

Do you think your employer satisfied with your job performance? Y N

RELIGION

Do you have a religious preference? Y N If yes, describe _____

Are your spiritual beliefs an important part of your life? Y N U

LEGAL

Have you ever been arrested/incarcerated? Y N if yes, when _____

Are you currently on probation/parole? Y N if yes, probation officer _____

Over the last two weeks, how often have you been bothered by any of the following problems?*

0=not at all 1=several days 2=more than half the days 3=nearly every day

1. <u>Little or no interest or pleasure in doing things.</u>	0	1	2	3
2. <u>Feeling down, depressed, hopeless.</u>	0	1	2	3
3. <u>Trouble falling asleep/staying asleep/sleeping too much.</u>	0	1	2	3
4. <u>Feeling tired or having little energy.</u>	0	1	2	3
5. <u>Poor appetite or overeating.</u>	0	1	2	3
6. <u>Feeling like you're a failure or you have let others down.</u>	0	1	2	3
7. <u>Trouble concentrating such as when reading or watching tv.</u>	0	1	2	3
8. <u>Moving or speaking so slowly that others may have noted, or being more fidgety or restless than usual.</u>	0	1	2	3
9. <u>Thoughts that you'd be better off dead/hurting yourself in some way.</u>	0	1	2	3
• <u>Trouble with everyday decisions.</u>	0	1	2	3
• <u>Trouble with important decisions.</u>	0	1	2	3
• <u>Feeling guilty about things that have happened in the past.</u>	0	1	2	3
• <u>Difficulty stopping tears/crying.</u>	0	1	2	3
• <u>Engaging in one or more self-destructive activities.</u>	0	1	2	3
• <u>Thoughts of killing or harming another.</u>	0	1	2	3
• <u>Hurting others with your words and/or actions</u>	0	1	2	3
• <u>Experiencing sexual problems.</u>	0	1	2	3
• <u>Criticizing yourself/getting down on yourself.</u>	0	1	2	3
• <u>Going for days without needing sleep.</u>	0	1	2	3
• <u>Experiencing extreme energy changes.</u>	0	1	2	3
• <u>Making impulsive decisions or increased risk-taking.</u>	0	1	2	3
• <u>Experiencing panic attacks.</u>	0	1	2	3
• <u>Worrying a lot/unable to relax.</u>	0	1	2	3
• <u>Difficulty going places by yourself.</u>	0	1	2	3
• <u>Avoiding (nonfamily) situations.</u>	0	1	2	3
• <u>Experiencing recurrent distressing dreams.</u>	0	1	2	3
• <u>Experiencing recurrent intense memories of a traumatic event.</u>	0	1	2	3
• <u>Finding it difficult to control your irritability or anger.</u>	0	1	2	3
• <u>Hearing or seeing things that others do not see or hear.</u>	0	1	2	3
• <u>Feeling that people are out to get you.</u>	0	1	2	3
• <u>Experiencing harm or harmful intentions from others.</u>	0	1	2	3
• <u>Difficulty interacting with others.</u>	0	1	2	3
• <u>Experiencing intense moods and mood swings.</u>	0	1	2	3
• <u>Trying to please others to the detriment of your own needs.</u>	0	1	2	3
• <u>Engaging in excessive checking/hoarding/cleaning.</u>	0	1	2	3

*If you checked any of the above, circle the difficulty level these problems have created for:

Work

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Taking care of things at home

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Getting along with others

Not difficult at all Somewhat difficult Very difficult Extremely difficult

*The PHQ-9 consists of the first 9 items. Copyright held by Pfizer, inc.