PSYCHOTHERAPEUTIC RESOURCES

CLINICAL INTAKE FORM

Name:_______________________________________ Today's Date:_______________

DOB:______________ Race:_______________

What would you like therapy to help you change? ____
____

REFERRAL SOURCE:____

In an effort to coordinate care, we would like to obtain/give information from previous providers and/or your referral source. With your written authorization, we will be informing your physician (by letter) of your diagnosis and care here, communicating (as necessary) with your referring agent and requesting past mental health records.

Please check: **YES**, and provide us with the names and addresses needed to prepare the authorization form(s) or check **No** if not necessary at this time.

Primary Care: ____ **Yes ____ No____***

Referral Source: ____ **Yes ____ No____***

Past Mental Health: ____ **Yes____ No____***

Were you raised by both biological parents? Y N If no, by whom?______________________

Were your biological/adoptive 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 half siblings or step siblings? Y N

Did you **OBSERVE ABUSE** OF <u>any family member in your **FAMILY OF ORIGIN**</u>? Y N DK

Were YOU **ABUSED/NEGLECTED** in your family of origin? Y N DK

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

Alcohol or drug abuse? Y N DK If yes, whom?___________________________

Significant depression? Y N DK If yes, whom?___________________________

Suicidal attempts? Y N DK If yes, whom?___________________________

Significant anxiety? Y N DK If yes, whom?___________________________

Mental illness? Y N DK If yes, whom?___________________________

Hospitalization for emotional problems? Y N DK If yes, whom?___________________________

Chronic physical illness? Y N DK If yes, whom?___________________________

Incarceration (jail/prison)? Y N DK If yes, whom?___________________________

Anger problems? Y N DK If yes, whom?___________________________

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:___________

OUTSIDE OF YOUR FAMILY OF ORIGIN, have you experienced abuse? Y N DK

Circle type of abuse: Sexual abuse Physical abuse Emotional abuse/harassment

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 committed relationship? Y N When?_____________
Name of spouse/significant other:____

Children (Include stepchildren)

First Name	Age	Year in School/Occupation	Living with you now?
			Y N
			Y N
			Y N
			Y N

Education

How many years of schooling have you completed?____ Diplomas/Degrees____________
Do you now have or have you had a learning disability? Y N DK

Employment

Are you presently employed? Y N Occupation/Employer:_______________________
Are you satisfied with your present job? Y N
Do you think your employer is satisfied with your current 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 DK

Legal

Have you ever been arrested/incarcerated? Y N When?___________________________

Stressors

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

Financial	Y N DK
Primary relationship (family/friends)	Y N DK
Housing	Y N DK
Physical health of self or family member	Y N DK
Access to health care	Y N DK
Occupation/employment	Y N DK
Legal	Y N DK
Education	Y N DK

Other____

If you scored any of the previous symptoms, 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

Current Use of Alcohol/Drugs

Circle average weekly alcohol intake: None 1-3 drinks 4-8 drinks More than 8
Circle recreational/mood enhancing nonprescription drug use: None Daily Weekly Monthly
Circle Type of Drug Used: Cannabis Cocaine Painkillers Speed Methamphetamine
Other___________________________________

In the last year have you experienced any of the following:

Picked up or charged with a drug-related driving offense?	Y N DK
Lost time from school or work because of use?	Y N DK
Experienced a medical problem because of use?	Y N DK
Been fired from a job because of use and its effects?	Y N DK
Felt you ought to cut down on your drinking or drug use?	Y N DK
Had people annoy you by criticizing your drinking or drug use?	Y N DK
Felt bad or guilty about your drinking or drug use?	Y N DK
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started?	Y N DK

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 or Chemical Dependency Treatment

(Include outpatient treatment and hospitalizations):

Dates (Month/Year)   Where   Primary Therapist
____
____
____