INTAKE INFORMATION

C O N F I D E N T I A L

Client Information

NAME: _____ **Date:** _____

DOB: _____ **Age:** _____ **SSN:** _____

Address: _____
Street City State Zip

Phone: Home (_____) _____ **Is it ok to leave a phone message?** (please circle) No Yes

Cell (_____) _____ **Is it ok to leave a phone message?** (please circle) No Yes

Email:

Please indicate other professionals, if any with whom you are currently working.

Name of Individual Therapist _____ **Phone #**_____

Name of Physician_____**Phone #**_____

Other Professional _____ **Phone #**_____

Please circle appropriate categories:

Citizenship: United States Other_____

School Information:

School Name: _____ **Major:** _____

Class: Freshman Sophomore Junior Senior 5th Year Graduate Transfer Student

School Status: Full time Part time Continuing Education

Employment Information:

Employment: Full time Part time # of Hours/week _____

Employer: _____

Residence: With Family Alone Roommates Dorm Off-Campus Other: _____

Referred by: Self Family Friend Doctor Counselor Advisor Administrator

Name/or Other_____

Health Insurance Information

Insurance Company Name : _____

Phone number for Mental Health Benefits (usually on the back of the card) : _____

Member ID number: _____

Financial Information

Financially Responsible Person:

__Self __Other (please specify)_____ **Phone #**_____

Emergency Contact:

Name:_____

Address:_____

Phone:_____Relationship to you:_____

INTAKE QUESTIONNAIRE

If you are uncomfortable answering any questions on this form, you may leave them blank. At our initial appointment we can review your answers in greater depth, help clarify your goals, and determine together an appropriate course of action.

Name/or Other_____

Please describe yourself as fully <u>as you feel comfortable</u>:

How much reluctance to you have about coming in for therapy today? Please circle one:

No reluctance at all Very little reluctance Some reluctance Quite a bit of reluctance Strong reluctance

If more than one applies to you, please check all that apply:

Gender
____Male
____Female
____Transgender
____MTF
____FTM
____Intersex

Relationship Status
____Single
____Married or Partnered
____Separated
____Divorced
____Widowed
____Other_____

Sexual Orientation
____Bi-Sexual
____Gay or Lesbian
____Heterosexual
____Questioning

Ethnicity/Race
____African-American
____Arab American
____Asian or ____Pacific Islander
____Caucasian, European-American
____Chicano, Latino, Hispanic
____Native or ____Alaskan Native
____Other_____

Religious affiliation/Spirituality:

Do you identify as having a disability? No Yes (please specify)

PRESENTING COMPLAINT:

Why are you seeking services at Beyond the Mirror?

Please circle all issues that currently concern you (write the number 1 and 2 next to the two most important topics):

Depression
Bipolar (Manic -Depression)
Anxiety
Alcohol Use
Substance Use
Eating /Body Image
Attention Deficit Disorder
Self-understanding
Self-acceptance
Self-care (hygiene, taking time for self)
Good Decision Making
Assertiveness
Stress Management
Clarification of Own Values
Grief
Working Through a Traumatic Event(s)
Other (specify):

Sexual Health Issues
Understanding Own Sexuality
  coming-out process
  sexual orientation
  gender identity
Adjusting to School/Work
Improved Relationships with:
  Friends
  Partner
  Family
Issues of Racial/Ethnic Identity
Respecting Cultural Differences
Understanding My Impact on Others
Decreasing Own Suicidal Thoughts
Eliminating/Reducing Unhealthy Behavior
Academic/Work Problems

HISTORY OF PRESENTING COMPLAINT:

When did you start having a problem with this?

How have you coped so far?

What strengths do you bring to this problem which will assist you in overcoming it?

Please circle all the following symptoms that you have experienced:

Recent (within the last month)	Past (one month ago or longer)
change in appetite	feelings of restlessness
significant weight gain/loss	trembling or shaking
change in mood	accelerated heart rate
irritability	shortness of breath
feelings of worthlessness	sweating
changes in sleeping patterns	chest pain
loss of energy	feelings of choking
loss of interest in activities	nausea
loss or decrease in sexual interest	recurrent thoughts of death
increase of energy	recurrent thoughts of wanting to commit suicide
difficulty concentrating	recurrent thoughts of harming others
nightmares	cutting or burning myself
substance abuse (alcohol or drugs)	seeing things that others do not
problems with attention, motivation, memory	hearing voices that others do not
recurrent and excessive anxiety or worry	paranoid thoughts

DESCRIBE YOUR CURRENT FUNCTIONING:

Currently, I am able to…	n/a	Never	Rarely	Sometimes	Frequently	Always
attend work/classes						
concentrate on duties /tasks/assignments						
maintain employment						
maintain satisfying relationship w/ significant other						
maintain satisfying relationships w/ family members						
initiate & maintain satisfying social relationships w/ peers						
take care of myself & participate in social/recreational activities						
decide on plans for future						
demonstrate adequate coping skills, esp under increased stress						
seek assistance when stress and problems are not manageable						
decrease substance abuse and/or other high-risk behaviors						

GPA (if applicable): Current? _____ Last Semester? _____ High School (optional)?_____

Are you thinking about leaving your job or school? No Yes

Are you at risk for being of being fired from your job or expelled from school? No Yes

Describe how this problem has affected your work and /or academic performance:

Describe struggles you are having in your relationships (friendships / dating / partner)?

Describe your support systems (friends, family, spiritual or cultural groups, etc.): Where do they live now?

Describe your past and current levels of exercise or physical activity:

PERTINENT PERSONAL/FAMILY HISTORY: (Please fill in information about yourself and your family members)

	Biological?	*Age*	*Occupation*	*Mental Health Concerns*	*Physical Health Concerns*	*Medical Concerns*
You	n/a					
Parent	Y N					
Parent	Y N					
Brother/Sister	Y N					
Brother/Sister	Y N					
Brother/Sister	Y N					
Child M F	Y N					
Child M F	Y N					
Child M F	Y N					
Others						

Are your parents married / separated / divorced / remarried? If divorced, how old were you at that time?

Describe your relationship with each parent:

Describe your relationship(s) with your sibling(s):

Describe your relationship(s) with your child/children:

Have you lost any direct family members? No Yes – Please list:

Do family members (grandparents, aunts, uncles, etc.) have a history of mental illness (depression, anxiety, etc.)? No Yes – Please list:

Is there a history of alcoholism in your extended family? No Yes – Please list:

MEDICAL HISTORY

Have you had…	*Recently (if yes, describe)*	*Past (if yes, describe)*
a head injury?	N Y	N Y
a seizure?	N Y	N Y
loss of consciousness?	N Y	N Y
significant injuries or illness?	N Y	N Y
medications prescribed?	N Y	N Y
known allergies to medications?	N Y	N Y
hospitalization for a medical condition?	N Y	N Y

Please list current medications: _____

PREVIOUS MENTAL HEALTH TREATMENT

Age	With Whom	How Long	Focus of Treatment	Helpful?	List Medications
				N Y	
				N Y	
				N Y	

Have you ever been hospitalized for mental health treatment? No Yes If yes, was it voluntary? No Yes

SUICIDAL/HOMICIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS

Have you ever had…	*Current (if yes, describe)*	*Past (if yes, describe)*
thoughts of hurting yourself?	N Y	N Y
thoughts of suicide?	N Y	N Y
a plan for suicide?	N Y	N Y
an attempted suicide?	N Y	N Y
thoughts of hurting someone else?	N Y	N Y
an incident of actually hurting someone else?	N Y	N Y

TRAUMA HISTORY

Have you ever been a victim of a crime? No Yes

Physical (e.g., car accidents, assault, abuse, head trauma)

Emotional (e.g., victim of crime, abuse, loss or death of relative / friend)

Sexual (e.g., sexual harassment, sexual assault)

LEGAL HISTORY: Have you ever been arrested or convicted of a legal violation?

SEXUAL ACTIVITY: Are you sexually active? No Yes

Do you use latex condoms or other safer sex techniques every time to prevent sexually transmitted diseases? No Yes

SUBSTANCE USE HISTORY: Please indicate your use of the following substances:

	List	Current Use		Past Use	
		Frequency # of days of the week	Amount Per Day	Frequency # of days of the week	Amount of Use Per Day
Alcohol		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Other		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

PLEASE DESCRIBE ANYTHING ELSE YOU WOULD LIKE TO TALK ABOUT:

PLEASE DESCRIBE YOUR GOALS FOR THERAPY: