INTAKE INTERVIEW FORM

Name:____________________

Social Security Number: ________________________

Home Address: _________________________

Date of Birth: ______________ **Age**: _________

Home Phone: ___________________________

City/State/Zip code: _____________________________

Cellular/Alternate Phone: ________________

Marital Status:	single	married	separated	divorced
	remarried	engaged	widowed	cohabiting

I. Family of Origin

A. Where were you born/raised? ____

B. Do you have any siblings? Y_____ N______

Sibling(s)' names and ages:

What is your birth order? (oldest, middle, etc.) ___________________________________

What was it like to be in that position in the family?

C. Are your parents still alive? Y N

Have they ever been married? Y N

Are your parents still married? Y N

Divorces/separations/step-parents? Y N

What are your living arrangements? _________________

Parents' nationality: Mother __________________

Is English her primary language? Y_____N_____

Father ___________________

Is English his primary language? Y_____N_____

Parents' occupation: Mother ___________________

Father ___________________

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INTAKE INTERVIEW FORM

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D. Family Mental Health History:

Anyone have history of drug abuse? Y____ N____

Who?

Alcohol addiction? Y____ N____

Who?

Mental illness, emotional disorders (depression, anxiety, bipolar, schizophrenia)? Circle all that apply

Who?

Learning disabilities (mental retardation, literacy deficits, hyperactivity) ? Circle all that apply

Who?

E. Have you ever been involved with the legal system?__________If so, please explain. ___________

____

F. Concerns re: family of origin ____

____

II. Occupation/Education:

Highest level of education achieved? ____

How well do you read and write? ____

Where do you go to school/work? ____

Any special education/disability programs? Y____ N____

Explain:

What type of student/employee are you?____

What are your likes/dislikes about school/work? ____

____

____

Current job? ____

Past employment positions (most recent to past):

Any job-related disabilities? Y____ N____

Explain:

Concerns re: school/education/work

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INTAKE INTERVIEW FORM

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III. Medical/Health History

Are you under a doctor's care? Y_____N ______

Dr.'s name/phone number ____

____

Do you have any allergies? N______Y______, list ______________________________

Are you currently taking any prescribed medication? Y_____ N _____

Type of medication (s) ____

____

Other than antibiotics, have you been on prescription medication in the past? Y_____ N_____

List: ____

Do you have any major health related concerns? Y_____ N _____

List: ____

Does your family have a history of health related concerns? Y_____ N _____

Do you smoke cigarettes? Y_____ N_____ How many? ______________

Do you ingest caffeine? Y_____ N_____ How much? ______________

Do you drink alcohol? Y_____ N_____ How much? ______________

Do you ingest non-prescription drugs? Y_____ N _____

What types? ____

Concerns re: medical/health status: ____________________________________

____

____

____

____

____

Any past trauma/abuse?____

____

____

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INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

If applicable, please complete the following:
Partner's Name: ____________________ **Partner's Age:** _______

Partner's Occupation: ____________________

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:
____
____
____
____
____

How long has this been going on? ____

What made you come in at this time? ____
____
____

What do you hope to gain from this evaluation and/or counseling?
____
____
____

If you had difficulties in the past, what have you done to cope? Was it helpful?
____
____
____

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INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

Symptoms
Please **check** any symptoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: ____________________

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed Mood
- ☐ Feeling Numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: ____________________
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Voluntary vomiting
- ☐ Eating less
- ☐ Excessive exercise to avoid weight gain
- ☐ Use of laxatives
- ☐ Are you trying to lose weight?
- ☐ Binge eating
- ☐ Weight gain: ________ lbs
- ☐ Weight loss: ________ lbs.

- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts
- ☐ Intrusive memories

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Please describe any other symptoms or experiences you have had problems with:

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INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

Please mark present symptoms with an "X":

	Always	Sometimes	Never
I have complaints of aches and pains			
I prefer to spend more time alone			
I tire easily, have little energy and/or sleep a lot			
I am having trouble with teacher/boss			
I am less interested in school/work			
I act as if I'm riding a motorcycle (hyperactive)			
I am impulsive, act without thinking			
I am distracted easily			
I am afraid of new situations			
I feel sad, unhappy			
I am irritable, angry			
I feel hopeless			
I have trouble concentrating			
I am less interested in friends			
I fight with others			
I hurt others intentionally			
I am abusive to animals			
Others feel that I cannot be trusted alone			
I lie frequently			
I engage in inappropriate sexual behavior			
I hurt myself on purpose			
I steal			
I am shy			
I choose to be absent from school/work			
My school/work performance is dropping			
I am down on myself			
I have trouble sleeping			
I eat poorly and/or have a history of eating disorders			
I worry a lot			
I feel lonely			
I feel like I am a bad person			

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INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

	Always	Sometimes	Never
I take unnecessary risks			
I get hurt frequently			
I seem to be having less fun			
Others say that I act younger than other my age			
I don't not listen to rules			
I don't show feelings/emotions			
I don't understand others feelings			
I tease or am verbally abusive to others			
I blame others for troubles			
I hear voices from nowhere			
Recent weight loss or gain and amount________			
Recent illness, virus or injury			
Irrational fears			
I have slowed or racing thoughts			
I am disoriented			
I worry about my life's outlook			
Labile (frequent mood swings)			
I have difficulty making decisions			
I feel guilty			
I have crying spells			
I have unusual thoughts			
I have irrational fears for my future			
I am tense			
I have memory problems			
I panic over things			
I am compulsive			
Others: (list)			

Are you suicidal or thinking of hurting yourself?__________________Or someone else ? ______________

Do you commit to talking to your counselor first should you feel seriously suicidal? ____________________

Date (s) and place (s) of previous out-patient counseling ____

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INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

Date (s) and place (s) of previous psychiatric treatment/hospitalization ______________________________

____

Date (s) and place (s) of chemical dependency treatment ____

____

Have you ever attended AA or anything similar? ____

Have you ever attempted suicide or tried to harm yourself? (when and how) __________________________

____

Have you ever attempted to harm someone else? (when and how) _________________________________

Have you ever taken a psychological test? (when and where) ____________________________________

IV. Social/Leisure Activities:

List your preferred leisure activities (hobbies, groups/organizations pastimes).

____

____

How many close friendships have you established? ____

How often do you engage in social activities? ____

How often do you engage in family activities? With whom? ___________________________________

____

Concerns re: social/leisure activity ____

____

V. AAT (Animal-Assisted Therapy) Experiences:

Animal experiences ____

Have you ever had a pet? ____

What happened to it?____

Any AAT previously? ____

Concerns re: animals, fears, environment, etc? ____

VI. Religious Background:

Do you have a preferred denomination? Y N

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INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

Which ? ____

What is/was your family's primary denomination? ______________________________

Are you currently active in a church? Y N

Describe____

Concerns re: religion/spiritual ______________________________________

VII. Goals:

What do you want from your counselor in your therapy experience? ____________________

____

What do you want to change in your own behavior or attitude? _______________________

____

Or in your situation? ____

____

Do you believe you need medication? Yes_____No _____

Are you open to medication? Yes_____No _____

Do you believe you need hospitalization? Yes_____No_____Why? __________________

How would you describe your childhood? (good, happy, sad, challenging, bad, complicated,traumatic)

Who did you live with growing up?

What is/was your relationship like with that guardian?

How do you feel that your upbringing has impacted your adult life?

Do you have a general distrust of people?

On a scale of 1-10 (10 being the strongest), what would rate your emotional healthiness?
1 2 3 4 5 6 7 8 9 10

Would your parent(s) or family member(s) be willing to come in if necessary? Yes______No ______

Are they willing to support your changes in other ways? (verbally, reading, etc.) Yes______No______

Please list the exact transformation goals you have for therapy: ______________________

____

____

____

____

______________________________ Client's signature

__________________ Date

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The Holmes-Rahe Scale

Read each of the events listed below and check the box next to any event which has occurred in your life in the last two (2) years. There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	**Life Crisis Units**	
Death of Spouse	100	
Divorce	73	
Marital Separation	65	
Gone to jail	63	
Death of close family member	63	
Personal injury or illness	53	
Marriage	50	
Fired at work	47	
Marital reconciliation	45	
Retirement	45	
Change in health of family member	44	
Pregnancy	40	
Sexual Difficulties	39	
Gain of new family member	39	
Business readjustment	39	
Change in financial state	38	
Death of a close friend	37	
Change to different line of work	36	
Increase in arguments with spouse	35	
Mortgage over $100,000	31	
Foreclosure of mortgage or loan	30	
Change in responsibilities at work	29	

Life Events	**Life Crisis Units**	
Son or daughter leaving home	29	
Trouble with in-laws	29	
Outstanding personal achievement	28	
Spouse begins or stops work	26	
Begin or end school	26	
Change in living conditions	25	
Revision in personal habits	24	
Trouble with boss	23	
Change in work hours or conditions	20	
Change in residence	20	
Change in schools	20	
Change in recreation	19	
Change in church activities	19	
Change in social activities	18	
Mortgage or loan less than $30,000	17	
Change in sleeping habits	16	
Change in number of family get-togethers	15	
Change in eating habits	15	
Vacation	13	
Christmas alone	12	
Minor violations of the law	11	

Your Total Score: ____

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