3.2.2 Intake & History Form (to be completed by client)

We know we ask a lot of questions. We do this to help us get an idea of who you are and what you need so we can serve you better. Some of the information is required for our licensing and funding. We apologize if any of the questions make you feel uncomfortable. Thank you for your understanding and cooperation.

Name: _____ Today's Date: _____/_____/_____

Pronoun: ☐ He/Him/His ☐ She/Her/Hers ☐ Ze/Hir/Zirs/Hirs ☐ They/Them/Theirs

II. Medical History

a. History: Would you describe your current physical health status as? ☐ excellent ☐ good ☐ fair ☐ poor

How many times in your life have you been hospitalized for medical/mental health/substance use problems? _____

Please list any recent (last twelve months) hospitalizations and/or emergency room contacts: _____

_____

_____

Do you have any chronic medical problems which continue to interfere with your life? ☐ Y ☐ N

If yes, please list them and describe whether you are able to self-manage them: _____

_____

_____

How seriously do these health problems currently impact your life?
☐ not at all ☐ mildly ☐ moderately ☐ severely ☐ extremely

Current Medication (include Herbals, Supplements, Vitamins and other treatments)

Medication	Do you take as prescribed?	List any difficulties and/or side effects
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	

If female, are you currently pregnant? ☐ Y ☐ N ☐ N/A

When was the last time you saw your healthcare provider for a physical examination (doctor, nurse practitioner, physician's assistant, healer, etc.)? ☐ Less than one year ago ☐ More than one year ago

Provider's Name: _____ Clinic's Name: _____

How many days out of the last 30 days you have experienced sickness and/or physical health problems (not caused directly by alcohol/drugs) _____ days (0-30)

BRIEF HEALTH HISTORY: Circle letter if have had or been treated for any of the following. Please also indicate whether you feel you can adequately manage the chronic health conditions yourself.

Condition	Treated or Had?		Well-Managed?		Condition	Treated or Had?		Well-Managed?	
Kidney Disease	☐Y	☐N	☐Y	☐N	Heart Defect (from birth)	☐Y	☐N	☐Y	☐N
Diabetes (Type I or II)	☐Y	☐N	☐Y	☐N	Heart attack before age 40	☐Y	☐N	☐Y	☐N
Hypoglycemia (low blood sugar)	☐Y	☐N	☐Y	☐N	Heart disease	☐Y	☐N	☐Y	☐N
Metabolic Syndrome (weight around middle & insulin resistant)	☐Y	☐N	☐Y	☐N	Stroke	☐Y	☐N	☐Y	☐N
Hypertension (high blood pressure)	☐Y	☐N	☐Y	☐N	Thyroid disease	☐Y	☐N	☐Y	☐N
High LDL (cholesterol)	☐Y	☐N	☐Y	☐N	Cancer , type _____	☐Y	☐N	☐Y	☐N
High Triglycerides	☐Y	☐N	☐Y	☐N	Enlarged Prostate (men)	☐Y	☐N	☐Y	☐N
Weight (over or under)	☐Y	☐N	☐Y	☐N	Menopause (women)	☐Y	☐N	☐Y	☐N
Chronic Obstructive Pulmonary Disease (COPD)	☐Y	☐N	☐Y	☐N	Asthma	☐Y	☐N	☐Y	☐N

SYMPTOMOLOGY

		Staff Only
Do you ever experience severe headaches? If **YES** → How often?_____	☐**Y** ☐**N**	CV
Do you ever experience blurry vision that comes and goes? **Other vision problems?**_____	☐**Y** ☐**N**	CV
Do you ever experience a rapid, uneven or heavy pulse/heartbeat? If **YES** → How often?_____	☐**Y** ☐**N**	CV, HT
Do you ever experience pounding in your chest, neck or ears? If **YES** → When was the last time?_____	☐**Y** ☐**N**	CV, HT
Do you ever have chest pain? If **YES** → When was the last time?_____	☐**Y** ☐**N**	CV, HT
Do you ever feel short of breath or have difficulty breathing? If **YES** → Does this ever happen when you are not moving? **Do you often feel irritated or stressed out?**	☐**Y** ☐**N** ☐**Y** ☐**N** ☐**Y** ☐**N**	CV, HT
Do you get tired or fatigued during the day? If **YES** → Do you have problems sleeping? If **NO** → Does your energy level drop suddenly? If **YES** → Do you wake up frequently? If **YES** → Do you have trouble going to sleep?	☐**Y** ☐**N** ☐**Y** ☐**N** ☐**Y** ☐**N** ☐**Y** ☐**N** ☐**Y** ☐**N**	 SD DB SD SA
Do you ever see blood in your urine, which may also look dark like tea? If **YES** → When was the last time?_____ If **YES** → Is there pain when you urinate?	☐**Y** ☐**N** ☐**Y** ☐**N**	CV, STI

BEHAVIORS

				Staff Only
How often do you eat fast food?	☐Once/wk or less	☐2-3x /week or more		CV,DB,WD
At home, what do you eat more of?	☐Vegetables/Grains	☐Meat/Dairy/Instant		CV,DB,WD
On an average day, which do you drink more of?	☐Water	☐Soda	☐Coffee/Tea	HT,DB,WD
How often do you exercise, including walking?	☐Daily	☐2-3x/week	☐1x/week or less	HT,CV,WD
How long do you exercise each time, on average?	☐45 min.+	☐30 min.	☐15 min. or less	
How many alcoholic beverages do you drink per week?	☐0-5	☐6-11	☐12 or more	SA,CV,WD,HT
How often do you use street drugs or pills not prescribed to you, excluding marijuana?	☐Daily	☐2-3x/week	☐1x/week or less	SA
How often do you smoke marijuana?	☐Daily	☐2-3x/week	☐1x/week or less	SA,CA
How often do have vaginal sex without a condom?	☐Always	☐Sometimes	☐Never	STI
How often do you have oral sex without a condom?	☐Always	☐Sometimes	☐Never	STI
How often do you have anal sex without a condom?	☐Always	☐Sometimes	☐Never	STI
How often do you have any kind of sex under the influence of alcohol or drugs?	☐Always	☐Sometimes	☐Never	SA,STI
How often do you share needles for injection?	☐Always	☐Sometimes	☐Never	SA,STI

***Risk Reduction Indicator Abbreviations**

CA	**Cancer Risk**	**CV**	**Cardiovascular**	**DB**	**Diabetes**	**HT**	**Hypertension**
SA	**Substance Abuse**	**SD**	**Stress/Depression**	**STI**	**HIV/Hepatitis/STI**	**WD**	**Weight and/or Diet**

Have you been tested for HIV? ☐ Y ☐ N Have you been diagnosed with HIV? ☐ Y ☐ N

Date of first HIV diagnosis: _____/_____/_____ Most recent HIV care provider visit: _____/_____/_____

Most recent CD4 Count: _____ Most recent Viral Load: _____

If you have been diagnosed with HIV, please check one of the following from your most recent visit:

☐ Symptomatic ☐ Asymptomatic ☐ Unknown

PRE-EXPOSURE PROPHYLAXIS (PrEP):

If you are living with HIV respond to the following questions	**Yes**	**No**	**Unknown**
1. Is your sexual partner(s) HIV positive?	☐	☐	☐
2. Have you engaged in condomless oral, anal or vaginal sex, particularly with an HIV-positive sex partner or someone whose HIV status you're unsure of?	☐	☐	☐
3. Do you have more than one sex partner, even if it is only once in a while?	☐	☐	☐
4. Does your partner(s) ever have other sex partners, or do you suspect they do?	☐	☐	☐
5. Do you ever use injection drugs?	☐	☐	☐
6. Did your partner(s) ever use injection drugs, or do you suspect them did?	☐	☐	☐
7. Do you exchange sex for money, housing, drugs, alcohol or other needs?	☐	☐	☐
8. Does your sex partner(s) exchange sex for money, housing, drugs, alcohol or other needs	☐	☐	☐

9. If you answered No to question #1, yes to any questions #2-#8, or unknown to any questions, you may benefit from more information on PrEP. If so, would you be interested in receiving information for your partner(s) about PrEP? ☐ Yes ☐ No

If you are not living with HIV respond to the following questions	**Yes**	**No**	**Unknown**
1. Is your sexual partner(s) HIV positive?*	☐	☐	☐
2. Have you engaged in condomless oral, anal or vaginal sex, particularly with an HIV-positive sex partner or someone whose HIV status you're unsure of?	☐	☐	☐
3. Do you have more than one sex partner, even if it is only once in a while?	☐	☐	☐
4. Does your partner(s) ever have other sex partners, or do you suspect they do?	☐	☐	☐
5. Do you ever use injection drugs?	☐	☐	☐
6. Did your partner(s) ever use injection drugs, or do you suspect them did?	☐	☐	☐
7. Do you exchange sex for money, housing, drugs, alcohol or other needs?	☐	☐	☐
8. Does your sex partner(s) exchange sex for money, housing, drugs, alcohol or other needs	☐	☐	☐
9. Have you been prescribed Pre-exposure Prophylaxis (PrEP) to reduce the risk of contracting HIV?	☐	☐	

10. If you answered yes or unknown to any questions #1-#9 you may be a candidate for PrEP. If so,
    a. Would you be interested in getting a referral to speak to a medical provider about PrEP? ☐ Yes ☐ No
    b. Would you be interested in receiving information for your partner(s) about PrEP? ☐ Yes ☐ No

* If your partner(s) is/are interested in getting a referral to speak to a medical provider about PrEP, please ask your counselor for more information.

Have you been tested for Hepatitis? ☐ Y ☐ N Please check the type you have tested for: ☐ A ☐ B ☐ C

When were you tested? ____/____/____ Was it positive? ☐ yes (check all that apply) ☐ A ☐ B ☐ C ☐ no

Have you had a Hepatitis vaccine? ☐ yes (check all that apply) ☐ A ☐ B ☐ no

Have you been tested for a sexually transmitted infection (other than HIV)? ☐ Y ☐ N
If you were diagnosed with an infection, were you fully treated? ☐ Y ☐ N

What is your TB status? ☐ Active ☐ Inactive ☐ No TB Date of last test: _____/_____/_____

Have you ever had a chest x-ray to screen for TB? ☐ Y ☐ N

TB Screening – do you currently have any of the following:

Persistent cough lasting 3 weeks or longer	☐ Y ☐ N	Bloody sputum	☐ Y ☐ N
Night sweats	☐ Y ☐ N	Weight loss	☐ Y ☐ N
Exposure to someone infected	☐ Y ☐ N	Fever	☐ Y ☐ N

Does anyone in your family or friends have significant medical/physical problems (for example: cancer, diabetes, heart disease, Alzheimer's)? If yes, please explain: _____

If yes, how does this affect you? _____

b. Smoking/tobacco use status (including e-cigarettes and smokeless tobacco):

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked ☐ Heavy tobacco smoker ☐ Light tobacco smoker

If you are a current user, are you interested in quitting in the next 30 days? ☐ Y ☐ N

If you are a former user of nicotine products, how long has it been since you quit? _____

c. Wellness Screen:

Based on your health screen above, please describe your short- and long-term physical health & wellness goals:

Short-term: _____

Long-term: _____

d. Nutrition Screen: Have you experienced any of the following in the last 30 days?

On a special diet ordered by a medical provider?	☐ Y ☐ N	Change in appetite	☐ Y ☐ N
Have you been following that diet?	☐ Y ☐ N	Dental problems	☐ Y ☐ N
Excessive use of laxatives	☐ Y ☐ N	Vomiting on purpose	☐ Y ☐ N
Unexplained weight loss of ≥10 pounds in last 90 days	☐ Y ☐ N	Loss of appetite	☐ Y ☐ N
Unexplained weight gain of ≥10 pounds in last 90 days	☐ Y ☐ N	Excessive or extreme exercising	☐ Y ☐ N
Bingeing on food	☐ Y ☐ N	Significant dissatisfaction with your body weight	☐ Y ☐ N

If you have answered yes to any of the above questions, please explain: _____

_____

If yes, is it being adequately addressed or treated by your physician? ☐ Y ☐ N

Food Allergies: For any foods, within minutes to 2 hours after eating a certain food, have you or your child ...

had a tingling sensation in your mouth	☐ Y ☐ N	Vomited	☐ Y ☐ N
had swelling of your tongue or throat	☐ Y ☐ N	had stomach cramps	☐ Y ☐ N
developed difficulty breathing	☐ Y ☐ N	had diarrhea	☐ Y ☐ N
broken out in hives	☐ Y ☐ N	had your blood pressure drop	☐ Y ☐ N
lost consciousness	☐ Y ☐ N		

e. Pain Screen: Do you currently have pain? ☐ Y ☐ N

If yes, is it affecting your daily functioning? ☐ Y ☐ N

If yes, is it being adequately addressed or treated by your physician? ☐ Y ☐ N

III. Mental Health Issues

a. History:

How many times have you been treated for any psychological or emotional problems?

In the hospital ____ Outpatient or private patient ____ Court ordered? ____

Previous Mental Health Diagnoses:

Diagnosis	Who diagnosed?	When was diagnosis given

Past Mental Health or Psychiatric experience:

Where	Month/Year	How Long	Was this helpful?	Psychiatric or Drug Related

Have you received counseling from (check all that apply)* ☐ psychiatrist ☐ psychologist
☐ psychotherapist/counselor ☐ drug counselor ☐ minister/priest ☐ other: (describe) _____

* If any of these past or current treatments are relevant to your current reason for treatment, give your counselor a release to request records and talk with that provider.

Have you had a significant period (that was not a direct result of drug/alcohol use) in which you have:

	Past 30 days	Lifetime	Comments
Experienced serious depression			
Experienced serious anxiety or tension			
Experienced hallucinations			
Experienced trouble understanding, concentrating or remembering			
Experienced trouble controlling anger that led to physical violence			
Experienced serious thoughts of suicide			
Attempted suicide			How?
Been prescribed medication for any psychological/emotional problem			
Wanted to hurt or harm yourself (including self-mutilation)			
Seriously wanted to hurt or harm someone else			Whom?

How many days out of the last 30 days you have experienced emotional and/or psychological problems (serious depression, anxiety or tension, hallucinations, trouble understanding, remembering, or concentrating serious thoughts of suicide or attempting suicide) _____ days (0-30)

Are you currently feeling suicidal? ☐ Y ☐ N **If yes, do you have a plan?** _____

Do you currently have problems sleeping? ☐ Y ☐ N
If yes, is it affecting your daily functioning? ☐ Y ☐ N
If yes, is it being adequately addressed or treated by your physician? ☐ Y ☐ N

Spijker, B. A., Batterham, P. J., Calear, A. L., Farrer, L., Christensen, H., Reynolds, J., & Kerkhof, A. J. (2014). The Suicidal Ideation Attributes Scale (SIDAS): Community-Based Validation Study of a New Scale for the Measurement of Suicidal Ideation. Suicide and Life-Threatening Behavior,44(4), 408-419. doi:10.1111/sltb.12084

b. Suicidal Ideation Attributes Scale (SIDAS)

1. In the past month, how often have you had thoughts about suicide?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Never Always
2. In the past month, how much control have you had over these thoughts?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
No control/ do not control Full control
3. In the past month, how close have you come to making a suicide attempt?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Not at all close Have made an attempt

4. In the past month, to what extent have you felt tormented by thoughts about suicide?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Not at all Extremely
5. In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as work, household tasks or social activities?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Not at all Extremely
6. Have you decided on a method to kill yourself? ☐ Y ☐ N

c. Death and Dying Issues:

Are you currently experiencing any difficulties related to grief/loss? ☐ Y ☐ N

If yes, would you like to address this in therapy? Please explain:_____

d. Grief/Loss Screen: Have you been experiencing any end-of-life issues or issues around grief/loss? ☐ Y ☐ N
Please describe: _____

e. Self-assessment/Expectations:

Describe your strengths: _____

Describe your weaknesses: _____

What (if anything) would you like to change about yourself? _____

What do you want as a result from your counseling? _____

IV. Education History

Check the highest grade you completed: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20 or ☐more

List degrees/other training you have received: _____
If you attended any technical training, how many months did you attend? _____

If you did not complete High School, what were the circumstances? _____

Any problems in school related to your orientation/gender? ☐ Y ☐ N
If yes, please explain: _____

Were you involved in extracurricular activities at school? ☐ Y ☐ N
If yes, what kind? _____

How did you get along with your classmates? _____

How did you get along with your teachers/staff?_____

What grades did you make in school? ☐ poor ☐ average ☐ good ☐ excellent

Would you like to go back to school? ☐ yes ☐ no If yes, what would you like to study? _____

Were you ever diagnosed with a learning disability? ☐ Y ☐ N

If yes, what was the disability? _____

Do you have any trouble reading, writing or with other basic skills? ☐ Y ☐ N
If yes, please explain: _____

How do you learn best? ☐ reading ☐ listening ☐ pictures ☐ demonstration ☐ video ☐ other _____

V. Employment/Income

Employment status: ☐ unemployed, not sought in past 30 days ☐ unemployed, sought in past 30 days
☐ unemployed, secured a position ☐ PT (<35 hrs/wk) ☐ FT (>35 hrs/wk) ☐ not in labor force

Usual employment pattern for past 3 years: ☐ FT 40 hrs/wk ☐ PT regular hrs ☐ student ☐ retired/disability
☐ PT irregular hrs ☐ military ☐ unemployed

Gross (before taxes) monthly income from all sources? $_____ per month. Monthly housing cost: $_____

What are your sources of that income: (check all that apply) ☐ job ☐ private disability ☐ retirement

☐ SSI/SSD ☐ workers comp ☐ parents ☐ unemployment ☐ food stamps ☐ TANF
☐ other: _____

Is this enough to support you/your family? ☐ Y ☐ N How many people depend on this income? _____

How many days out of the last 30 days you have experienced employment and/or school problems (poor attendance, poor performance, missed appointments, inability to work) _____ days (0-30)

Is there anything about your work causing problems for you? _____
Current occupation/job title: _____ Length of time at this job: _____
Current Employer: _____

List past employers and dates over the past five years:

Employer	Job Title	Reason for Leaving

If unemployed, how long? _____ Reason: _____
Are you able to work? ☐ Y ☐ N
Do you want to work? ☐ Y ☐ N What kind of job would you like to have? _____
Are you interested in career counseling or training? ☐ Y ☐ N

What outstanding debts (credit cards, loans, fines, household expenses) are causing you problems? _____

VI. Military History ☐ Y ☐ N

If yes: Current status: _____Branch of Service: _____ Where: _____
Type of Discharge: _____ Rank at Discharge: _____
If yes: do you have any family members (spouse/partner, children) who need services? ☐ Y ☐ N
Active combat? ☐ yes ☐ no Dates of Service: _____/_____/_____ to _____/_____/_____
Did you experience enemy fire/see combat/witness casualties? ☐ Y ☐ N
Are you accessing Veterans Administration Services? ☐ Y ☐ N
Are you the spouse/partner, child or dependent family member of a veteran/active duty military? ☐ Y ☐ N

VII. Parenthood

Do you have any children/stepchildren? ☐ Y ☐ N If yes, please list:

Name of Child	Age	Name of Child	Age	Name of Child	Age	Name of Child	Age

Do they live with you? ☐ Y ☐ N Are any of your children currently in foster care? ☐ Y ☐ N

Do any of your children/stepchildren have any special problems such as learning disabilities, medical condition, handicaps, etc.? ☐ Y ☐ N If yes, please explain: _____

VIII. Alcohol and Drug Usage

AUDIT C

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Check the choice that best describes your answer to each question.

How often do you have a drink containing alcohol in the past year?

☐ Never[0] ☐ Monthly or less[1] ☐ 2-4 times a month[2] ☐ 2-3 times a week[3] ☐ 4 or more times a week[4]

How many drinks containing alcohol do you have on a typical day when you are drinking in the past year?

☐ 0 drinks[0] ☐ 1 or 2[0] ☐ 3 or 4[1] ☐ 5 or 6[2] ☐ 7 to 9[3] ☐ 10 or more[4]

How often do you have 5 or more drinks on one occasion in the past year?

☐ Never[0] ☐ Less than monthly[1] ☐ Monthly[2] ☐ Weekly[3] ☐ Daily or almost daily[4]

The AUDIT is reprinted with permission from the World Health Organization. www.who.org. Excerpted from NIH Publication No. 07-3769 National Institute on Alcohol and Alcoholism www.niaaa.nih.gov/guide

When was the last time you had a drink containing alcohol? _____ How many drinks?_____

In the PAST YEAR, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Which medication(s)?_____
When was the last time you used?_____How much did you take?_____

In the PAST YEAR, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Which drug(s)?_____
When was the last time you used?_____How much did you use?_____

In the PAST 3 MONTHS,
have you tried and failed to control, cut down or stop drinking or using drugs/medications? ☐ Y ☐ N
has anyone expressed concern about your drinking or drug/medication use? ☐ Y ☐ N

Have you ever had any of the following happen as a result of drinking or drug/medication use?

☐ lost a job ☐ overdosed ☐ lost time ☐ legal consequences (DWI, PI, jail, probation)
☐ injected drugs with needles ☐ health problems ☐ mental health problems

In the past year, has your alcohol/drug usage: ☐ Increased ☐ Decreased ☐ Remained the same

Are you seeking help for an alcohol or drug/medication use problem? ☐ Y ☐ N ☐ Not sure
Are you interested in a working with a recovery coach? ☐ Y ☐ N ☐ Not sure
Are you seeking intensive outpatient treatment (IOP) for substance use? ☐ Y ☐ N ☐ Not sure

Gambling

How often do you gamble? ☐ never ☐ rarely ☐ sometimes ☐ often
Are you having financial problems because of gambling? ☐ Y ☐ N
Do you believe that your gambling is negatively affecting your life? ☐ Y ☐ N ☐ don't know

IX. Family/Childhood Relationship History

Relationship status: ☐ coupled/married ☐ widow(er) ☐ separated ☐ divorced ☐ never coupled/married

What have been your usual living arrangements for the past 3 years?
☐ w/ sexual partner & children ☐ w/ sexual partner alone ☐ w/ children alone ☐ parents ☐ family
☐ friends ☐ alone ☐ controlled environment

Are you satisfied with these arrangements? ☐ no ☐ indifferent ☐ yes

Are any of your children living with someone else due to a child protection order or foster care? ☐ Y ☐ N

How many days in the past 30 days have you had serious conflicts: with your family _____ with other people ____

(Please list members in family while growing up (Mother, Father, Step-parents, brothers/sisters and other significant family)

First Name	**Living?** *(Yes or no)*	**Age**	**City Where Living**	**Describe Relationship** *(close, conflict, distant)*	**Acceptance of Your Sexual/Gender Orientation** *(accepting, not accepting or don't know)*
(Parent)	☐Y☐N				
(Parent)	☐Y☐N				
(Sis/Bro)	☐Y☐N				
(Sis/Bro)	☐Y☐N				
(Sis/Bro)	☐Y☐N				
(Step-parent)	☐Y☐N				
(Other)	☐Y☐N				
(Other)	☐Y☐N				

Please list any significant family members not listed above here: _____

With whom did you spend the majority of your childhood? (check one) ☐ both biological parents
☐ one biological parent ☐ one biological & a step-parent ☐ other: _____

How did your family get along? (check all that apply) ☐ peacefully ☐ argued a lot ☐ loving
☐ no communication ☐ respectful ☐ yelling/screaming ☐ violent ☐ other: _____

How many times did you move growing up? _____

How were you punished? (check all that apply) ☐ grounded ☐ spanked ☐ beaten with belt or cord, etc.
☐ privileges taken away ☐ other: _____

Were you and your siblings treated the same? (check one) ☐ Y ☐ N
If no, please describe: _____
What were your primary feelings as child? _____

Has anyone in your family experienced problems with drug/alcohol abuse or psychiatric problems ? ☐ Y ☐ N
If yes, please explain: _____

X. Legal History

Do you have any court actions or legal charges pending? ☐ Y ☐ N If yes, what is it for? _____

Please describe present legal status/issues (check all that apply):
☐ none ☐ separation/divorce ☐ child custody battle ☐ bankruptcy ☐ lawsuits ☐ public intoxication
☐ DWI probation ☐ awaiting trial ☐ non-DWI probation ☐ pretrial diversion/deferred adjudication
☐ parole ☐ awaiting sentencing ☐ in jail/prison/work release ☐ criminal case pending
Special conditions of probation/parole: _____

Have you ever had your driver's license ever suspended/revoked? ☐ Y ☐ N
If yes, describe: _____

Please indicate the number of arrests you had in the last 12 months: (___) none (___) DWI
(___) public Intoxication (___) drug/alcohol related
(___) other misdemeanor arrests (explain): _____
(___) other felony arrests (explain) _____

Have you ever been investigated by child protective services? ☐ Y ☐ N
If yes, is the case still open? ☐ Y ☐ N
If yes, please describe the circumstances: _____

Will any legal problems interfere with your counseling or treatment? ☐ Y ☐ N
If yes, please explain: _____

Are any of the legal issues listed above causing Difficulty with your mental health? ☐ Y ☐ N

Have you completed the following documents for yourself? General durable power of attorney? ☐ Y ☐ N
Medical power of attorney? ☐ Y ☐ N Living will? ☐ Y ☐ N Will? ☐ Y ☐ N
Arrangements for minor children? ☐ Y ☐ N Psychiatric Advanced Directives? ☐ Y ☐ N
Burial/memorial service arrangements? ☐ Y ☐ N If yes to above, who has the information?

Name:_____

XI. Abuse History

Were you ever abused as a child?		As an adult?	
physically	☐ Y ☐ N	☐ Y ☐ N	
Emotionally	☐ Y ☐ N	☐ Y ☐ N	
Sexually	☐ Y ☐ N	☐ Y ☐ N	

If you are currently in a relationship, does your partner do any of the following without your consent:
try to control where you go or what you do? ☐ Y ☐ N
force or coerce you to have sex or hurt you during sex? ☐ Y ☐ N
slapped, pulled, shoved, hit, kicked, burned, punched, restrained you, or deprived you of food, water, money or sleep? ☐ Y ☐ N

If you are in a relationship, have you hit/physically abused/battered your partner? ☐ Y ☐ N ☐ N/A

Have you been sexually harassed in the past? ☐ Y ☐ N If yes, when and where: _____

Have you been targeted for a bias/hate crime? ☐ Y ☐ N

If yes, what type of incident was it (check all that apply) ☐ physical assault ☐ verbal assault
☐ property damage ☐ intimidation ☐ sexual assault ☐ written statements ☐ other: _____

Date(s) the incident(s) occurred: _____

Do you feel the attack was because of your perceived (check all that apply) ☐ race ☐ sexual orientation
☐ religion ☐ gender ☐ ethnicity ☐ disability

XII. Sexual/Relationship History

How old were you at the time of your first sexual experience: _____ Was it consensual? _____

How old were you when you became aware of your orientation? _____

If transgender, how old were you when you became aware of your gender identity issues? _____

Current feelings about your orientation/gender identity: ☐ acceptance ☐ pride ☐ conflicted ☐ avoiding
☐ hidden ☐ other: _____

Please describe any past or present problems with self-acceptance or acceptance by others regarding your gender or orientation: _____

_____

What best describes your level of sexual activity (check one) ☐ abstinent ☐ active ☐ very active

Who are your sexual partners? (check all that apply) ☐ male ☐ female ☐ transgender

Are you satisfied with your level of sexual activity? ☐ Y ☐ N
If not, what would you like to be different? _____

Do you practice safer sex? ☐ never ☐ sometimes ☐ mostly ☐ always

Please identify your current relationship status (check all that apply) ☐ single ☐ dating ☐ significant other ☐ married ☐ domestic partner ☐ committed ☐ open relationship ☐ monogamous ☐ separated ☐ divorced ☐ widow(er)/bereaved ☐ other: _____

Partner's/Partners' first name(s): _____ Age(s): _____ Together how long: _____

Describe relationship: ☐ supportive ☐ indifferent ☐ conflicted ☐ violent ☐ unsure ☐ other: _____

Does your partner have any physical challenges or special needs? ☐ Y ☐ N
If yes, Please explain: _____

Are you seeking couples counseling? ☐ Y ☐ N

How many days out of the last 30 days you have experienced family and/or marital problems (missed responsibilities, not caring for children, serious argument, verbal or physical abuse, serious conflict due to poor communication or lack of trust) _____ days (0-30)

Previous Significant Relationships

Partner's First Name	Dates (year)	Reason for Separation
	To	
	To	
	To	
	To	

Did any of the people listed above (current or previous) have a history of alcohol/drug and/or psychiatric problems? ☐ Y ☐ N If yes, please explain: _____

XIII Cultural/Spiritual/Religious History

Do you have any cultural values, beliefs, or traditions that you think may have an impact on your ability to participate in counseling? ☐ Y ☐ N
If yes, explain: _____

Were you raised in a particular religion or spirituality? ☐ Y ☐ N If yes, what? _____

Do you believe in God or a Higher Power? ☐ Y ☐ N

Do you actively practice your religion? ☐ Y ☐ N If yes, describe: _____

How important are your spiritual/religious beliefs in your life?
☐ not at all ☐ somewhat ☐ very much ☐ source of problems

Describe any problems your religious upbringing or beliefs may be causing you: _____

_____

XIV. Social/Leisure/Support Network

What are your hobbies or leisure activities? _____

_____

Do you currently do these things? ☐ Y ☐ N If no, why not? _____

Do people generally like you? ☐ Y ☐ N If no, why not? _____

What kind of things do you do with your friends? _____
Do you currently do these things ☐ Y ☐ N If no, why not? _____

Do you have friends/family that you can talk to when you have a problem? ☐ Y ☐ N

How many days out of the last 30 days you have experienced peer and/or social relationships problems (excluding family) (missed responsibilities with friends or others, serious argument, verbal or physical abuse, serious conflict due to poor communication or lack of trust) _____ days (0-30)

I have read the statement of client rights and responsibilities and have answered all questions on this form to the best of my ability. I am requesting services from the Montrose Center.

_____ _____/_____/_____
Client's Signature Date

STAFF USE ONLY:

This form was completed by: ☐ client ☐ staff ☐ other/relationship: _____

____ Consent for services explained and form signed.
____ Client gave times for therapy and a phone number at the top of the Consent for Services.
____ Fees were explained and initialed by client.
____ Client signed the Consent for Emergency Medical Care and gave contacts and doctor.
____ Client signed client portion of the intake.
____ Check date of birth, and is 60+, complete the AAA forms and explain about SPRY.

13.3.3 PATIENT HEALTH QUESTIONNAIRE-9

Client's Name: _____ Date: _____/_____/_____

	Over the last two weeks, how often have you been bothered by any of the following problems? Use "√" to indicate your answer.	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	○	○	○	○
2	Feeling down, depressed or hopeless	○	○	○	○
3	Trouble falling or staying asleep or sleeping too much	○	○	○	○
4	Feeling tired or having little energy	○	○	○	○
5	Poor appetite or overeating	○	○	○	○
6	Feeling bad about yourself -or that you are a failure or let yourself or your family down	○	○	○	○
7	Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8	Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9	Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○
	Add columns			+	+
	Total				
10	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?	Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult ○			

Please turn over and complete questions on reverse side.

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenle, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr. Spitzer at rls8@colunbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at hhtp://www/Pfizer.com. Copyright © 1999 Pfizer Inc. All rights reserved. PRIME MD TODAY trademark of Pfizer Inc.

GAF Score _____ Date Admin: _____/_____/_____

Circle One:
1st Assessment 2nd Assessment

Staff Name: _____

13.3.7 GENERALIZED ANXIETY DISORDER ASSESSMENT (GAD-7) & BRIEF RESILIENCE SCALE (BRS)

Client's Name: _____ Date: ____/____/____

GAD-7: Please read each statement and record a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	◯ 0	◯ 1	◯ 2	◯ 3
2	Not being able to stop or control worrying	◯ 0	◯ 1	◯ 2	◯ 3
3	Worrying too much about different things	◯ 0	◯ 1	◯ 2	◯ 3
4	Trouble relaxing	◯ 0	◯ 1	◯ 2	◯ 3
5	Being so restless that it is hard to sit still	◯ 0	◯ 1	◯ 2	◯ 3
6	Becoming easily annoyed or irritable	◯ 0	◯ 1	◯ 2	◯ 3
7	Feeling afraid as if something awful might happen	◯ 0	◯ 1	◯ 2	◯ 3
	Total GAD-7 score = + + +				

The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. GAD-7 © Pfizer Inc. all rights reserved; used with permission.

	BRS: Please respond to each item by marking one box per row:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I tend to bounce back quickly after hard times	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
2	I have a hard time making it through stressful events.	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
3	It does not take me long to recover from a stressful event.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
4	It is hard for me to snap back when something bad happens.	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
5	I usually come through difficult times with little trouble.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
6	I tend to take a long time to get over set-backs in my life.	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered.

My score: _____ item average / 6 = _____

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. International journal of behavioral medicine, 15(3), 194-200.