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 ☐ They/Them/Theirs ☐ Ze/Hir/Zirs/Hirs ☐ Other ____________

II. Mental Health Issues

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

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

Please select all options below that apply, to either current or previous treatment you have received*:

☐ psychiatrist ☐ psychologist ☐ drug counselor ☐ psychotherapist/counselor ☐ minister/priest
☐ court ordered treatment ☐ inpatient ☐ outpatient ☐ other: (describe) __________________

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

Counselor, Hospital, Provider, Psychiatrist Name	Type of Treatment	Start/End Dates	Diagnoses Given	Was it helpful?
	☐ inpatient ☐ outpatient ☐ mental health ☐ substance use			☐ Y ☐ N ☐ Unsure
	☐ inpatient ☐ outpatient ☐ mental health ☐ substance use			☐ Y ☐ N ☐ Unsure
	☐ inpatient ☐ outpatient ☐ mental health ☐ substance use			☐ Y ☐ N ☐ Unsure
	☐ inpatient ☐ outpatient ☐ mental health ☐ substance use			☐ Y ☐ N ☐ Unsure
	☐ inpatient ☐ outpatient ☐ mental health ☐ substance use			☐ Y ☐ N ☐ Unsure

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 issue			
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 issues (serious depression, anxiety or tension, hallucinations, trouble understanding, remembering, or concentrating serious thoughts of suicide or attempting suicide) _____ days (0-30)

III. Suicide/Homicide Assessment

Are you currently feeling suicidal? ☐ Y ☐ N

If you are currently feeling suicidal, do you have a plan? ☐ Y ☐ N

If yes, please describe: _____

Have you decided on a method to kill yourself? ☐ Y ☐ N

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

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

IV. 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:_____

V. Alcohol and Other Drug Usage

AUDIT C

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 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 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**,
have you tried and failed to control, cut down or stop drinking or using substances? ☐ Y ☐ N
has anyone expressed concern about your drinking or substance use? ☐ Y ☐ N
Have you experienced any of the following as a result of drinking or substance use?
☐ loss of a job or other employment problems ☐ overdosed ☐ cravings ☐ lost time
☐ legal consequences (DWI, PI, jail, probation) ☐ injected drugs with needles
☐ physical health problems ☐ mental health problems
Has your alcohol/substance usage: ☐ Increased ☐ Decreased ☐ Remained the same

Are you seeking help for an alcohol or drug/medication use issue? ☐ 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
If yes, are you being required to complete substance use treatment by a probation officer or court? ☐ Y ☐ N

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

VI. Abuse History

As a child, were you ever abused:		As an adult, were you ever abused:	
physically	☐ Y ☐ N	physically	☐ Y ☐ N
Emotionally	☐ Y ☐ N	emotionally	☐ Y ☐ N
Sexually	☐ Y ☐ N	sexually	☐ Y ☐ N

If you are currently in a relationship, do(es) your partner(s) 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

VII. HIV Health History

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

Year of first HIV diagnosis: _____ Most recent HIV care provider visit: _____/_____/_____
Status: ☐ Detectable ☐ Undectable ☐ Unknown HIV Medical Provider Name: _____
Where do you receive your HIV medical care: _____

VIII. Sexual Health History

Pre-Exposure Prophylaxis (PrEP) is a medication that can be taken to prevent HIV.

The following questions help determine if PrEP is right for you or your partner(s):	**Yes**	**No**	**Unknown**
Are you (or your partner[s]) HIV positive?	☐	☐	☐
Have you (or your partner[s]) engaged in condomless oral, anal or vaginal sex?	☐	☐	☐
Do you (or your partner[s]) have more than one sex partner, even if it is only once in a while?	☐	☐	☐
Do you (or your partner[s]) ever use injection drugs?	☐	☐	☐
Do you (or your partner[s]) exchange sex for money, housing, drugs, alcohol or other needs?	☐	☐	☐
Have you (or your partner[s]) been prescribed Pre-exposure Prophylaxis (PrEP) to reduce risk of contracting HIV?	☐	☐	☐
Would you (or your partner[s]) be interested in a referral for PrEP?	☐	☐	

What best describes your level of sexual activity? (check one) ☐ abstinent ☐ active
Are you satisfied with your level of sexual activity? ☐ Y ☐ N
If not, what would you like to be different? _____
How often do you practice safer sex? ☐ never ☐ sometimes ☐ mostly ☐ always
What safer sex methods do you practice: ☐ none ☐ condoms/barriers ☐ PrEP ☐ other:_____

Sexually Transmitted Infection (STI)

Have you been tested for Hepatitis? ☐ Y ☐ N
If yes, please check the type you were tested for: ☐ A ☐ B ☐ C
When were you tested? ____/____/____ Was it positive? ☐ Y ☐ N
If positive, which type (*check all that apply*): ☐ A ☐ B ☐ C
Have you had a Hepatitis vaccine? ☐ Y ☐ N
If yes, which type (*check all that apply*): ☐ A ☐ B

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 ☐ N/A

Please respond to the following questions:

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**

IX. Sexual Orientation and Gender Identity History

What words do you use to describe your sexual orientation? _____
How old were you when you became aware of your sexuality? _____
What words do you use to describe your gender identity? _____
How old were you when you became aware of your gender identity? _____

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

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

_____

Do you need information, assistance, or referrals related to: ☐ coming out ☐ exploring gender identity ☐name/pronoun changes ☐ accessing hormones/HRT ☐ gender affirming surgery ☐ unsupportive family ☐ religious/spiritual trauma

Do you want any of the information provided above under **Sexual Orientation and Gender Identity History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

X. Relationship History

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

How old were you at the time of your first sexual experience: _____

Was it consensual? ☐ Y ☐ N ☐ Unsure ☐ N/A

Current sexual or romantic partner(s):

Partner's Name	Age	Gender Identity	Together How Long	Description
				☐ supportive ☐ conflicted ☐ distant
				☐ supportive ☐ conflicted ☐ distant
				☐ supportive ☐ conflicted ☐ distant
				☐ supportive ☐ conflicted ☐ distant

Do(es) your partner(s) have any physical challenges or special needs? ☐ Y ☐ N ☐ N/A
If yes, please explain: _____

Are you seeking couples/relationship counseling? ☐ Y ☐ N

Check the box that best describes your degree of happiness, everything considered, based on your present relationship(s). If you have multiple partners, please add the each partner's name to the choice that corresponds to them. If you are not currently in a relationship, please skip to Previous Significant Relationship History.

Name	very unhappy	happy	perfectly happy
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Have you or your partner(s) ever engaged in any behavior that one of you would consider infidelity, cheating, or going outside the relationship? ☐ Y ☐ N ☐ N/A

Have you considered ending your current relationship(s)? ☐ Y ☐ N ☐ N/A

My partner(s) and I are having problems in the following area(s) (check all that apply):

☐ emotional connection ☐ feeling respected ☐ intense/unpleasant arguments ☐ trust ☐ job stress
☐ level of romance/passion ☐ sex life ☐ handling hard life events ☐ raising children
☐ family/in-law acceptance ☐ jealousy ☐ affair or infidelity ☐ separation/divorce ☐ teamwork
☐ influencing decisions ☐ finances ☐ having fun together ☐ being part of a community together
☐ spirituality ☐ other: _____

Are there issues, concerns, or things listed below items that you want to explore or discuss in therapy related to your sexuality or relationships? Please check all that apply:

☐ sexual desire ☐ sexual pleasure ☐ sexual functioning ☐ consent ☐ protection from STIs
☐ kink/BDSM ☐ fetishes ☐ drug/alcohol use ☐ masturbation ☐ content of fantasies ☐ pornography
☐ other: _____

Previous Significant Relationship History

Partner's First Name	Age	Together how long	Description
			☐ supportive ☐ distant ☐ conflicted ☐ violent ☐ unsure ☐ other: _____
			☐ supportive ☐ distant ☐ conflicted ☐ violent ☐ unsure ☐ other: _____
			☐ supportive ☐ distant ☐ conflicted ☐ violent ☐ unsure ☐ other: _____

How many days out of the last 30 days you have experienced relationship issues? (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)

Do you want any of the information provided above under **Relationship History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XI. Family/Childhood Relationship History

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 ☐ other: _____

Are you satisfied with these arrangements? ☐ Y ☐ N ☐ indifferent

How many days in the past 30 days have you had serious conflicts: with your family ____ days (0-30)

(Please **list members in family** while growing up (Parents, grandparents, step-parents, guardians, siblings and other significant family)

First Name	Relationship	Age	City Where Living	Describe Relationship	Acceptance of Your Sexual/Gender Orientation
		Age: ___ ☐ deceased		☐ close ☐ conflicted ☐ distant	☐ accepting ☐ not accepting ☐ don't know
		Age: ___ ☐ deceased		☐ close ☐ conflicted ☐ distant	☐ accepting ☐ not accepting ☐ don't know
		Age: ___ ☐ deceased		☐ close ☐ conflicted ☐ distant	☐ accepting ☐ not accepting ☐ don't know

		Age: ___ ☐ deceased		☐ close ☐ conflicted ☐ distant	☐ accepting ☐ not accepting ☐ don't know
		Age: ___ ☐ deceased		☐ close ☐ conflicted ☐ distant	☐ accepting ☐ not accepting ☐ don't know
		Age: ___ ☐ deceased		☐ close ☐ conflicted ☐ distant	☐ accepting ☐ not accepting ☐ don't know
		Age: ___ ☐ deceased		☐ close ☐ conflicted ☐ distant	☐ accepting ☐ not accepting ☐ don't know

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 ☐ N/A
If no, please describe: _____
What were your primary feelings as child? _____

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

Do you want any of the information provided above under **Family/Childhood Relationship History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XII 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, describe? _____

What words do you use to describe your religious/spiritual beliefs now? _____

Do you actively practice any religious/spiritual rituals? ☐ Y ☐ N If yes, describe: _____
How important are your spiritual/religious beliefs in your life?
☐ not at all ☐ somewhat ☐ very much ☐ source of issues

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

_____

Do you want any of the information provided above under **Cultural/Spiritual/Religious History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XIII. Social/Leisure/Support Network

What are your hobbies or leisure activities you do for self-care? _____

_____

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 an issue? ☐ Y ☐ N

How many days out of the last 30 days you have experienced peer and/or social relationships issues (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)

Do you want any of the information provided above under **Social/Leisure/Support History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XIV. 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
☐ DUI probation ☐ awaiting trial ☐ non-DUI probation ☐ pretrial diversion/deferred adjudication
☐ parole ☐ awaiting sentencing ☐ in jail/prison/work release ☐ criminal case pending ☐ assault
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 (___) DUI
(___) 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 issues 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:_____

Do you want any of the information provided above under **Legal History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XV. Medical 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 issues? _____

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

____

____

Medical History (include herbals, supplements, vitamins and other treatments)

Medical Diagnosis	Medication or Treatment	Can you self-manage this diagnosis?	How seriously does this diagnosis/condition impact your life?	Taken as prescribed?	Side effects/difficulties?	If any side effects, how badly do they affect you?
		☐ Y ☐ N	☐ not at all ☐ mildly ☐ moderately ☐ severely ☐ extremely	☐ Y ☐ N		☐ none ☐ mild ☐ moderate ☐ severe
		☐ Y ☐ N	☐ not at all ☐ mildly ☐ moderately ☐ severely ☐ extremely	☐ Y ☐ N		☐ none ☐ mild ☐ moderate ☐ severe
		☐ Y ☐ N	☐ not at all ☐ mildly ☐ moderately ☐ severely ☐ extremely	☐ Y ☐ N		☐ none ☐ mild ☐ moderate ☐ severe
		☐ Y ☐ N	☐ not at all ☐ mildly ☐ moderately ☐ severely ☐ extremely	☐ Y ☐ N		☐ none ☐ mild ☐ moderate ☐ severe
		☐ Y ☐ N	☐ not at all ☐ mildly ☐ moderately ☐ severely ☐ extremely	☐ Y ☐ N		☐ none ☐ mild ☐ moderate ☐ severe

Are you currently pregnant? ☐ Y ☐ N ☐ Unsure ☐ 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 issues (not caused directly by alcohol/drugs) _____ days (0-30)

Brief Health History: Check all applicable boxes 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?	☐**Y** ☐ **N** If **YES** → How often?_____	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?	☐**Y** ☐ **N** If **YES** → How often?_____	CV, HT
Do you ever experience pounding in your chest, neck or ears?	☐**Y** ☐ **N** If **YES** → When was the last time?_____	CV, HT
Do you ever have chest pain?	☐**Y** ☐ **N** If **YES** → When was the last time?_____	CV, HT
Do you ever feel short of breath or have difficulty breathing?	☐**Y** ☐ **N** If **YES** → Does this ever happen when you are not moving? ☐**Y** ☐ **N**	CV, HT
Do you often feel irritated or stressed out?	☐**Y** ☐ **N**	
Do you get tired or fatigued during the day?	☐**Y** ☐ **N** If **YES** → Do you have trouble sleeping? ☐**Y** ☐ **N** If **NO** → Does your energy level drop suddenly? ☐**Y** ☐ **N** If **YES** → Do you wake up frequently? ☐**Y** ☐ **N** If **YES** → Do you have trouble going to sleep? ☐**Y** ☐ **N**	SD DB SD SA
Do you ever see blood in your urine, which may also look dark like tea?	☐**Y** ☐ **N** If **YES** → When was the last time?_____ If **YES** → Is there pain when you urinate? ☐**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?	☐N/A	☐Daily	☐2-3x/week	☐1x/week or less	SA
How often do you smoke marijuana?	☐N/A	☐Daily	☐2-3x/week	☐1x/week or less	SA,CA

***Risk Reduction Indicator Abbreviations: CA Cancer Risk, CV Cardiovascular; DB Diabetes, HT Hypertension, SA Substance Abuse, SD Stress/Depression, STIHIV/Hepatitis/STI, WD Weight and/or Diet**

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

If yes, how does this affect you? _____

Do you currently have trouble sleeping? ☐ Y ☐ N If yes, is it affecting your daily functioning? ☐ Y ☐ N

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

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

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

Do you currently have any of the following: (check all that apply)

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

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		

Nutrition Screening: 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 you have answered yes, are they being adequately addressed or treated by your physician? ☐ Y ☐ N

Pain Screening:
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
If yes, please describe the pain you are experiencing: _____

_____

Nicotine Use Screening (including cigarettes, e-cigarettes/vapes, chewing tobacco, etc.):
☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked
If you currently use nicotine, please choose one: ☐ 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? _____

Do you want any of the information provided above under **Nicotine Use** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

Wellness Goals:
Based on all of your health screenings above, please describe your short- and long-term physical health & wellness goals:

Short-term: _____

Long-term: _____

XVI. Education History

Check the highest grade you completed: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐ GED
☐ Some College ☐ Trade/Technical/Vocational Training ☐ Assocate's Decgree
☐ Bachelor's Degree ☐ Master's/Professional Degree or Higher

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? _____

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 _____

Do you want any of the information provided above under Education History to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XVII. Employment/Income History

Current 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? _____

Current occupation/job title: _____ Length of time at this job: _____
Current Employer: _____

Is there anything about your work causing issues for you? ☐ Y ☐ N ☐ N/A
If yes, explain: _____

If you have been unemployed in the past, please list the reason(s) for leaving your previous employment: _____

_____

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 issues? _____

_____

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

Do you want any of the information provided above under **Employment/Income History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XVIII. Military History

Do you have a personal history in the military? ☐ Y ☐ N (If yes, please complete this section)

Current status: _____Branch of Service: _____ Where: _____
Type of Discharge: _____ Rank at Discharge: _____

Do you have any family members (spouse/partner, children) who need services? ☐ Y ☐ N

Active combat? ☐ yes ☐ no Dates of Service: _____/_____/_____ to _____/_____/_____

Are you accessing Veterans Administration Services? ☐ Y ☐ N

Did you experience enemy fire/see combat/witness casualties? ☐ Y ☐ N

Are you the spouse/partner, child or dependent family member of a veteran/active duty military? ☐ Y ☐ N

Do you want any of the information provided above under **Military History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XIX. Parenthood History

Do you have any children/stepchildren? ☐ Y ☐ N If yes, please complete the table below:

Name of Child	Age	Do they live with you?	In foster care?	Foster care is due to a child protective order?	Does this child have any special problems such as a learning disability, medical condition, handicap, etc.?	If yes, please explain
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	

Do you want any of the information provided above under **Parenthood History** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

XX. 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? _____

Do you want any of the information provided above under **Self-Assessment/Expectations** to be included as part of your treatment? (Please note that even if you say no now, you can still add these items to your treatment at a later date) ☐ Y ☐ N

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	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself -or that you are a failure or let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	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.

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.