Clinical Intake Update

Today's Date:___/___/___

Name_____ D.O.B.____/____/____ Age:_____
Address_____
City_____ Zip_____
Home Phone # _____
Cell Phone # _____

It is often beneficial to provide or exchange information with your other health providers for the most complete care. Are you willing to sign a Release of Information form so that we may coordinate care with your other providers? ___No ___Yes

When you have completed therapy, what would you like to be different in your life?

_____

_____

Goals

What skills would you like to build?

___Stress management
___Anxiety management
___Setting boundaries with others
___Build self-esteem
___Create more balance in life
___Develop better partnering skills
___Communication skills
___Conflict resolution
___Being able to say no
___Build confidence in skills and abilities
___Build parenting strategies
___Skills to manage depression

CURRENT SYMPTOM CHECKLIST

In at least the last 2 weeks, how often have you been bothered by any of the following problems?
0=not at all; 1=several days; 2=more than half the days; 3= nearly every day

Group A

___depressed mood/feeling down/hopeless
___having a plan for how to end your life
___significant weight loss
___little interest or pleasure in doing things
___fatigue or loss of energy
___thinking you would be better off dead
___trouble concentrating or indecisiveness
___significant weight gain
___restlessness/fidgety
___feelings of worthlessness
___feelings of excessive or inappropriate guilt
___moving or speaking so slowly that other people could have noticed
___trouble falling asleep/staying asleep/sleeping too much

Place a check next to the following symptoms that have occurred in the past 6 months:

Group B

___social isolation or withdrawal
___low self-esteem
___being unusually irritable
___lack of motivation
___feelings of hopelessness
___severe mood swings
___lack of personal hygiene or grooming
___difficulty stopping tears
___self-injurious or harmful behavior (cutting, scratching, burning)

Group C

__ periods of ***abnormally and persistently*** elevated, high or irritable mood
___periods of ***abnormally and persistently*** increased energy or focus on a task
___significant periods of overblown self- esteem
___significant periods of feeling grandiose; (that you could do anything)
___periods of decreased need for sleep ***without feeling tired***
___more talkative than usual or pressure to keep talking
___racing thoughts
___easily distracted by unimportant things
___*extreme* focus on "getting things done" at school, work, or home.
___excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling)

Group D

___excessive or senseless worrying
___it is difficult to control the worry

As a result of the worry you experience:

___restlessness or feeling keyed up
___irritability
___sleep disturbance
___being easily fatigued
___muscle tension

Group E

___panic attacks; frequency_____

Symptoms associated with panic attacks:
(check all that apply)

___heart pounding or rapid heart rate
___trembling or shaking
___feelings of choking
___nausea or abdominal upset
___hot or cold flashes
___feeling "unreal" or detached from self
___sweating
___sensations of shortness of breath or smothering
___chest pain or discomfort
___feeling faint, dizzy, or unsteady on feet
___numbness or tingling sensations
___fear of losing control or "going crazy"
___fear of dying
___having to go with others in order to feel comfortable
___avoiding everyday places for fear that you can't escape or that you will have a panic attack

Group F

___considerable fear or anxiety about situations in which you may be judged (e.g. having a conversation; meeting new people)
___being observed (e.g. eating or drinking)
___performing in front of others

___persistent, excessive phobia (heights, closed spaces, specific animals, etc.)
Please list_____
___recurrent and bothersome thoughts, ideas or images that are unwanted and cause anxiety
___you have tried to ignore the thoughts or stop them with some other action
___repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, repeating) that must be done or you feel anxious
___needing to have things done a certain way or client becomes very upset
___the obsessions are time consuming

Group G
___experienced, witnessed, or learned of an actual or threatened death, serious injury, or sexual violence
Traumatic event:_____
___recurrent and upsetting thoughts of the trauma
___recurrent distressing dreams related to the trauma
___flashbacks in which it feels like the trauma is reoccurring
___intense or ongoing psychological distress to events that resemble the trauma
___intense physical symptoms of panic or fear to events that resemble the trauma
___spending effort avoiding thoughts or feelings associated with a past trauma
___persistent avoidance of people, places, or activities that cause you to remember the trauma
___inability to recall an important aspect of the trauma
___persistent negative beliefs (e.g. "I am bad," "No one can be trusted," "The world is not safe")
___distorted thoughts about why the trauma happened causing you to blame yourself or others
___constantly negative emotional state (e.g. fear, anger, guilt)
___marked decreased interest in important activities
___feeling detached or distant from others ___feeling numb or restricted in your feelings
___feeling that your future is shortened ___quick startle response
___feeling like you are always watching for bad things to happen

Group H
___trouble sustaining attention or being easily distracted ___lacking attention to detail
___restless, fidgety ___makes decisions impulsively
___trouble maintaining an organized work or living area ___difficulty completing projects
___feeling overwhelmed by the tasks of everyday living ___impatient, easily frustrated
___frequent traffic violations or near accidents ___inconsistent work performance
___making comments to other without considering their impact
___difficulty delaying what you want; having to have your needs met immediately

Group I
___restriction of food intake that leads to a less than normal body
___intense fear of gaining weight or becoming fat event though at a significantly low weight
___engaging in persistent behaviors that interfere with weight gain
___persistent over concern with body shape and weight
___lack of recognition of the seriousness of the current low body weight
___recurrent episodes of binge eating large amount of food

___eating, in a certain time frame, definitely larger amounts of food than most people would eat in the same time
___a sense of lack of control over eating during the episode
___recurrent activities such as self-induced vomiting and/or the misuse of laxatives, water pills, strict dieting or excessive exercise

Group J

___seeing things which are not real ___hearing sounds or voices which are not real
____peculiar behaviors ___marked lack of initiative
___delusional or bizarre thoughts (thoughts you know others would think are false)
___seeing objects, shadows or movements that are not real
___periods of time where your thoughts or speech are not connected or do not make sense to you or others
___severely impaired ability to function at home or at work
___inappropriate mood for the situation (i.e. laughing at sad events)
___frequent feelings that someone or something is out to hurt you or discredit you
___periods of extreme irritability, physical or verbal aggression or rage

Severity Measure for Depression—Adult*

*Adapted from the Patient Health Questionnaire–9 (PHQ-9)

Instructions: Over the **last 7 days**, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

						Clinician Use
						Item score
		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 have 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	
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Adapted from Patient Health Questionnaire—9 (PHQ-9) for research and evaluation purposes.

Severity Measure for Generalized Anxiety Disorder—Adult

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
2.	felt anxious, worried, or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
6.	avoided, or did not approach or enter, situations about which I worry	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
7.	left situations early or participated only minimally due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
9.	sought reassurance from others due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
10.	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

Relationships

Marital Status: (check all that apply)

__not currently in a relationship __currently in a relationship (for how long?_____)
__engaged (for how long?_____) __married (for how long?_____)
__divorced(for how long?_____) __separated (for how long?_____)
__divorce in process (for how long?_____) __live-in partner (for how long?_____)
__widowed (for how long?_____)
prior marriages (self) ___ prior marriages(partner)___

On a scale of 1-10 how would you rate your satisfaction with your relationship?_____

How would you describe your partner? (Check all that apply)

___Warm ___Understanding __Perfect ___Indifferent ___Distant
___Argumentative ___Uncaring ___Boring ___Happy ___Engaging
___Unpleasant ___Tense ___Unhappy ___Enjoyable ___Abusive
___Affectionate ___Judgmental ___Unforgiving

Relationship Concerns (if any):

___past affairs ___current affairs ___trust issues ___poor communication
___finances ___lack of time together ___verbal abuse ___physical abuse
___substance abuse

Sexual Health:
On a scale of 1-10 how would you rate your sexual satisfaction? _____

Sexual Health Issues:

During foreplay, intercourse, or partnered sexual stimulation, do you experience any of the following? (please check all that apply):

___ lack of arousal ___ lack of genital sensation (tingling/warmth/excitement)
___difficulty achieving orgasm ___ loss of orgasm intensity (muffled or short in duration)
___ vaginal dryness ___ erectile difficulty
___ decreased sense of connection with partner ___ genital pain -If so, please describe
___ lack of focus on/awareness of sexual feelings ___lack of desire
___ difficulty with sexual response (quick, slow or intermittent)
___fetishes

Substance Use

On the average, how often do you drink alcohol?

___Never ___Once or twice a year ___Daily ___Once a week
___Once a month ___Several times a week

On the average, how much do you drink? ___1-3 drinks ___4-8 drinks ___8 or more

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

Which of the following have you used?

___None	___Cocaine	___Barbiturates	___Crack
___LSD, Angel Dust	___Opium	___Heroin	___Marijuana
___PCP	___Crank	___Amphetamines	___Tranquilizers
___Mushrooms	___Acid	___Pain pills w/o a prescription	

Have any of these been used in the last 12 months? ___No ___

Substance use status:

__no history of abuse	__active abuse	__early full remission
__early partial remission	__sustained full remission	__sustained partial remission

Recent Treatment history:
__*outpatient*: Month/Year_____
Facility:_____
City/State_____

__*inpatient:* Month/Year_____
Facility:_____
City/State_____

__12-step program: __stopped on own: __other: _____
Have you received a DUI or DWI? ___No ___Yes /When_____

Do you smoke cigarettes? ___No, never have ___No, I quit ___Yes/How many per day?_____

How many caffeinated beverages to you consume daily, on average?
___None ___1 ___2 ___3 ___4 ___5+

Mental Health

Are you currently under the care of a psychiatrist? ___No ___Yes
If yes, Name: _____Clinic:_____

Have you previously been involved in counseling? ____Individual ____Marital ____Family

If yes, Name:_____Clinic:_____
Are you willing to sign a release of information for records? ___No ___Yes

Have you recently been hospitalized for mental health issues or suicidal thoughts?
___No ___Yes/When:_____

Strengths

How would you describe your strengths?

___Smart	___Funny	___Resourceful	___Caring
___Good work ethic	___Organized	___Wise	___Well-balanced
___Enthusiastic	___Passionate	___Helpful	___Multi-tasker
___Positive	___Good listener	___Calm under pressure	___Good communicator

Physical Health

Are you currently under the care of a doctor or other health practitioner? ___No ___Yes
If yes, Name: _____ Clinic:_____

Describe your current physical health: ___Excellent ___Good ___Fair ___Poor

Have you had any major illnesses or hospitalizations recently? ___No ___Yes
If yes, Explain:_____

Current Medications (if any):
Medication_____ Dose: _____
Medication_____ Dose: _____
Medication_____ Dose: _____

How many hours of sleep do you get? ___hours ___delayed sleep ___early waking

Do you exercise regularly? ___No ___Yes ___Try to

Do you have any known allergies? ___No ___Yes If yes, please describe:_____
_____