ADULT CLINICAL INTAKE **Date:___/___/___**

Name____ **D.O.B.**____/____/____ **Age:**__________
Address____
City____________________________________ **Zip**_________________
Home Phone # ____________________ May we leave a message? Yes/No
Cell Phone # ______________________ May we leave a message? Yes/No

Can we give you a reminder call by phone? ____Yes ____No

It is your responsibility to inform Milestone Counseling of changes in address, phone number, and insurance coverage.

Occupation: _________________________________ **Employer:**__________________________

Who referred you? ____

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

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:	

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CURRENT SYMPTOM CHECKLIST

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

Group B

___having a plan for how to end your life
___social isolation or withdrawal
___low self-esteem
___being unusually irritable
___lack of motivation
___feelings of excessive or inappropriate guilt
___self-injurious or harmful behavior (cutting, scratching, burning)
___restlessness/fidgety
___feelings of hopelessness
___severe mood swings
___lack of personal hygiene or grooming
___difficulty stopping tears

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 anxiety or worry
___being easily fatigued
___it is difficult to control the worry
___irritability as a result of worry

Group E

___panic attacks; frequency__________

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

___feelings of choking
___nausea or abdominal upset
___numbness or tingling sensations
___fear of losing control or "going crazy"
___having to go with others in order to feel comfortable
___chest pain or discomfort
___hot or cold flashes
___feeling "unreal" or detached from self
___fear of dying

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

FAMILY HISTORY

Who primarily raised you?

___both biological parents ___adoptive parents
___biological mother and stepfather ___biological father and stepmother
___biological mother ___biological father
___grandparents

Parents' current marital status:

___married to each other ___never married or together
___parents divorced when client was ___years old
___mother deceased for ___years *age of client* at mother's death___
___father deceased for ___year *age of client* at father's death___

Family Members:

number of brothers _____ sisters _____
birth order of client: ___ of ___ siblings
number of step brothers_____ sisters____
number of half- brothers____ sisters_____
deceased family members______________

How would you describe your childhood?

___Happy ___Frightening ___Unhappy ___Dull
___Hard to remember ___Secure ___Regimented ___Sad
___Painful ___Delightful ___Problematic ___Normal

Did you witness abuse as a child?

___No ___Yes ___Emotional ___Verbal ___Physical ___Sexual
If yes, by whom:____

Did you experience abuse as a child?
___No ___Yes ___Emotional ___Verbal ___Physical ___Sexual
If yes, by whom:____

Mother/father/siblings have experienced the following problems:
alcohol/drug abuse: __mother __father __siblings(s) __grandparent(s)
significant depression: __mother __father __siblings ___grandparent(s)
significant anxiety: __mother __father __siblings ___grandparents(s)
*other known mental illness in the family:*____
suicide or suicide attempt: __mother __father __siblings ___grandparents(s)
anger problems: __mother __father __siblings ___grandparents(s)
jail/prison: __mother __father __siblings ___grandparents(s)

Please list your biological, step, and adopted children:

Name	Age	Living w/you	Name	Age	Living w/you
____________	____	Y/N	____________	____	Y/N
____________	____	Y/N	____________	____	Y/N
____________	____	Y/N	____________	____	Y/N

Are there any other persons living in your home? ___Yes___No
If yes, whom?____

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 ___finances
___lack of time together ___verbal abuse ___physical abuse ___substance abuse
___poor communication

Sexual Identity/Gender Identity:

___heterosexual ___gay ___ lesbian ___bi-sexual ___questioning ___pansexual
___asexual ___transgender (preferred prefix:________) ___transsexual ___transitioning

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

SOCIO-ECONOMIC/CULTURAL HISTORY

Living situation: (check all that apply)

__housing adequate __homeless __housing overcrowded
__dependent on others for housing __housing dangerous/deteriorating

Financial situation:

__no current financial problems __large indebtedness
__poverty or below poverty level __impulsive spending
__relationship conflicts over finances

Social support system:

__supportive network __a few friends __substance use-based friends
__no friends __distant from family of origin

Employment:

__employed and satisfied __employed but dissatisfied __unemployed
__supervisor conflicts __unstable work history __coworker conflicts

Education (Check all that apply):

____Graduated High School ____GED ____ Attended some college ____years
____ Graduated College: Diploma/Degrees Earned:______________________________
____Learning difficulties: if checked specify______________________________

Cultural Identity:

Please indicate the nationality or ethnicity that you identify with: ______________________

Have you ever served in the military?
____Yes _____No
If yes, what were the terms of your discharge?
____Still on active duty ____ Honorable discharge (mental health)
____ Honorable discharge (physical health) ____ Honorable discharge
____ Dishonorable discharge ____ Does not apply

Legal:
__no current legal problems __now on parole/probation
__arrest(s) not substance related __arrest(s) substance-related
__jail/prison_____ time(s) Total time served ____months/___years
Describe last legal difficulty____
__this treatment is court ordered

Spiritual:
What, if any, is your religious preference?_______________________________
Are your spiritual beliefs an important part of your life? ____Yes _____No

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 ___Yes

Substance use status:
__no history of abuse __active abuse __early full remission
__early partial remission __sustained full remission __sustained partial remission

Treatment history:
__*outpatient*: Month/Year_________________________
Facility:____
City/State____

__*inpatient:* Month/Year_________________________
Facility:____
City/State____

__12-step program: __stopped on own:

Have you ever 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 do 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 ever 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:_________________

____