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Intake Information: Confidential!

Client Information:

Name: _____ Date: _____

DOB: _____ Age: _____ SSN: _____

Address: _____

_____

Phone # Home (_____) _____ Is it ok to leave a voicemail message here? (please circle) Y N

Cell (_____) _____ Is it ok to leave a voicemail message here? (please circle) Y N

Work (_____) _____Is it ok to leave a voicemail message here? (please circle) Y N

Email:_____

Please indicate other professionals, if any, with whom you are currently working:

Name of Physician _____ Phone #_____

Name of Psychiatrist: _____ Phone # _____

Name of Other Therapist(s)_____ Phone #_____

_____ Phone #_____

Other Professional(s) _____ Phone #_____

Please circle the appropriate categories:

Citizenship: United States Other _____ **Note: Your citizenship status will not be used against you!**

School Information:

School Name: _____ Major: _____

Class: Freshman Sophomore Junior Senior 5th year Graduate Transfer Student

Years in School: _____ School Status: Full time Part time Continuing Education

Last year completed in school: _____ Degree(s) Received _____ GPA (current): _____

GPA (Last semester): _____ GPA (high school / overall): _____

Employment Information:

Employment: Full time Part time #Hours/week _____ Paid: Salary Hourly Amount _____ per hour year

Employer: _____ Position: _____

Residential Information:

Residence: With Family Alone Roommates Dorm Off-Campus Other:

Other People residing in the home (Names and ages): _____

_____

Therapy Information:

Referred by: Self Family Friend Doctor Counselor Advisor Administrator Other: _____

Name of Referral Source: _____

Have you ever had psychotherapy /counseling before: (please circle) Y N

If so, was this therapy: (circle all that apply) Inpatient Outpatient

Where did the therapy and/or hospitalizations take place? _____

How long did it last: _____

Were you satisfied? (please circle) Y N

Health Insurance Information:

Insurance Company Name: _____ Name of Policy Holder: _____

Place of Employment of Policy Holder: _____

Birth Date of Primary Insurance Holder: _____

Phone Number for Mental Health Benefits (usually on the back of the card): _____

Member ID #:_____ Group ID#: _____

Financial Information:

Person Financially Responsible for Payment:

_____ Self _____ Parent/Family Member _____ Other (please specify) _____

Phone # for responsible party: _____

Address for responsible party: _____

_____

Emergency Contact(s):

Name(s): _____

Address(es): _____

_____

Phone #s: _____ _____ _____
Home *Cell* *Work*

Relationship(s) to you: _____

Intake Questionnaire:

If *you are uncomfortable answering any questions on this form, you may leave them blank. At our initial appointment, we can review your answers in greater depth, help clarify your goals, and determine together an appropriate course of action.*

Please Describe Yourself as fully as you feel comfortable:

How much reluctance do you have about coming in for therapy today? Please circle only one:

None at all Very little Some Quite a bit Strong Don't want to be here at all!

If more than one of these applies to you, please check all that apply:

Gender

_____ Male
_____ Female
_____ Transgender
  _____ MTF
  _____ FTM
_____ Intersex
_____Unsure/Other

Relationship Status

_____ Single
_____ Married or Partnered
_____ Separated
_____ Divorced
_____ Widowed
_____ Other _____

Sexual Orientation

_____ Bi-Sexual
_____ Gay or Lesbian
_____ Heterosexual
_____ Questioning
_____ Other: _____

Ethnicity / Race

_____ African-American
_____ Arab American
_____ Asian or Pacific Islander
_____ European American (Caucasian)
_____ Chicano, Latino, Hispanic
_____ Native American
_____ Other: _____

Religious Affiliation/Spiritual Orientation: _____

Do you identify with having a disability? No Yes (please specify) _____

Presenting Complaint:
Why are you seeking services with Dr. Burlingame-Lee at this time?

Please circle all issues that currently concern you. Write the number 1 and 2 next to the most important issues:

Depression
Bipolar Disorder ("Manic/Depressive")
Anxiety
Alcohol Use / Abuse
Substance Use / Abuse
Eating / Body Image
Attention Deficit Disorder
Self-Understanding
Self-Acceptance
Self-Care (Hygiene, Taking Time for Self)
Good Decision Making
Assertiveness
Stress Management
Clarification of My Values
Grief
Working Through a Traumatic Event(s)
Decreasing my Self-Harming Urges
Working Through Abuse Issues
Autism / Asperger's

Sexual Health Issues
Understanding My Sexuality
  Coming-out process
  Sexual Orientation
  Gender Identity
Adjusting to School and/or Work
Improving Relationships with:
  Friends
  Partner
  Family
Issues of Racial / Ethnic Identity
Respecting / Working with Cultural Differences
Understanding My Impact on Others
Decreasing My Suicidal Thoughts
Eliminating / Reducing Unhealthy Behavior
Academic / Work Problems
Dealing with Past Trauma
Personality Disorders
Other: _____

H**istory of Presenting Complaint:**

When did you start having a problem with this?

How have you coped so far?

What strengths do you bring to this problem which will assist you in overcoming it?

Please put a check or X by all the following symptoms that you have experienced:

Recent (within the last month) = ✓
Past (one month ago or longer) = X

Change in appetite
Significant weight gain / loss
Change in mood
Irritability
Feelings of worthlessness
Changes in sleeping pattern (_____More _____Less)
Loss of energy
Loss of interest in activities
Loss or decrease in sexual interest
Increase of energy
Difficulty concentrating
Nightmares
Substance Abuse (alcohol or drugs)
Problems with attention, motivation or memory
Recurrent and excessive anxiety or worry
Intense or out of control anger / rage
Trouble getting along with others
Feeling out of control (specific): _____

Feelings of restlessness
Trembling or shaking
Accelerated heart rate
Shortness of breath
Sweating
Chest pain
Feelings of choking
Nausea
Recurrent thoughts of death
Recurrent thoughts of wanting to commit suicide
Recurrent thoughts of harming others
Recurrent thoughts of wanting harm myself (like cutting or burning)
Seeing things that others do not see
Hearing voices or sounds that other do not hear
Paranoid thoughts
Feeling "outside of your body" or that you've mentally "gone somewhere else"

Describe Your Current Functioning:

Currently I am able to:	***N/A***	***Never***	***Rarely***	***Sometimes***	***Frequently***	***Always***
Attend work / classes						
Concentrate of duties / tasks / assignments						
Maintain employment / school attendance						
Maintain a satisfying relationship with a significant other						
Maintain satisfying relationships with family members						
Initiate and maintain satisfying peer relationships						
Take care of myself						
Participate in social / recreational activities						
Decide on plans for the future						
Demonstrate adequate coping skills, especially under increased stress						
Seek assistance when stress and problems are not manageable						
Decrease substance abuse and / or other high risk behaviors						

Current Functioning, Continued:

Are you thinking about leaving your job or leaving school? No Yes (Why?)_____

Are you at risk for being fired from your job or expelled from school? No Yes (Why?) _____

Describe how this problem has affected your work and/or academic performance?

Describe struggles you are having in your relationships (family / friendships / dating / partner)?

Describe your support systems (friends, family, spiritual or cultural groups, colleagues, etc.) How close are they to you, geographically?

Describe your past and current levels of exercise or physical activity:

Pertinent Family History:

Person Involved	*Biological?*	*Age*	*Occupation*	*Mental Health Concerns*	*Physical Health Concerns*	*Medical Concerns*
You	N/A					
Parent (Mo)	Y N					
Parent (Fa)	Y N					
Sibling (M / F)	Y N					
Sibling (M / F)	Y N					
Sibling (M / F)	Y N					
Partner (M / F)	N/A					
Child (M / F)	Y N					
Child (M / F)	Y N					
Child (M / F)	Y N					
Others:						

Are your parents married / separated / divorced / remarried? If divorced, how old were you at that time? _____

Briefly describe your relationship with each parent:

If you have siblings, briefly describe your relationship(s) with your sibling(s)?

If you have children, briefly describe your relationship(s) with your child / children?

Have you lost any direct family members: No Yes – (please list)

Do family members (grandparents, aunts, uncles, etc.) have a history of mental illness / emotional problems? No Yes - Please list:

Is there a history of alcoholism and/or substance abuse in your immediate or extended family? No Yes – Please list:

Medical History

Have you had:	*Recently:*	*If yes, describe:*	*Past:*	*If yes, describe:*
A head injury?	N Y		N Y	
A seizure?	N Y		N Y	
Loss of consciousness?	N Y		N Y	
Significant injuries or illness?	N Y		N Y	
Medications prescribed? (Please list below)	N Y		N Y	
Known allergies to medications?	N Y		N Y	
Hospitalization for a medical condition?	N Y		N Y	
Hospitalization for a psychiatric condition??	N Y		N Y	

Please list current medications: _____

_____

Previous Mental Health Treatment:

Age	***With Whom***	***How Long***	***Focus of Treatment***	***Helpful?***	***Medications Prescribed***

Suicidal / Homicidal / Assaultive Thoughts or Behaviors:

Have you ever had…	***Current***	***If yes, describe***	***Past***	***If yes, describe***
Thoughts of hurting yourself?	N Y		N Y	
An incident of actually hurting yourself?	N Y		N Y	
Thoughts of suicide?	N Y		N Y	
A plan for suicide?	N Y		N Y	
An attempted suicide?	N Y		N Y	
Thoughts of hurting someone else?	N Y		N Y	
An incident of actually hurting someone else?	N Y		N Y	

Trauma History:

Have you ever been a victim of a crime? No Yes If yes, please describe the incident:

Physical (e.g., car accidents, assault, abuse, head trauma): No Yes If yes, please describe:

Emotional (e.g., victim of crime, abuse, loss or death of a relative / friend): No Yes If yes, please describe:

Sexual (e.g., sexual harassment, sexual assault, sexual abuse): No Yes If yes, please describe:

Legal History: Have you ever been arrested or convicted of a legal violation? (*Note: answering "yes" to this question will not necessarily mean that you are ineligible for therapy services)*

Sexual Activity: Are you sexually active: No Yes

If yes, do you use latex condoms or other safer sex techniques every time to prevent sexually transmitted disease and/or unwanted pregnancy? No Yes

Substance Abuse History:

Type of Substance:	**Current Use:** ***Frequency*** ***# days per week***	***Amount per day***	**Past Use:** ***Frequency*** ***# days per week***	***Amount per day***
Alcohol				
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs (non-prescribed)				
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine				
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco				
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Other				
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Type:	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

Adapted from Intake Information, Beyond the Mirror, 2012

Please Describe Anything Else You Would Like To Talk About:

Please Describe Your Goals For Therapy:

If you have had therapy in the past, what worked best for you and what didn't work for you?