

**INTAKE INFORMATION**

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**CONFIDENTIAL**

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**INTAKE QUESTIONNAIRE**

Date: \_\_\_\_\_

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

PHONE: Home (\_\_\_\_\_) \_\_\_\_\_ Is it ok to leave a phone message? (please circle) No Yes

Cell (\_\_\_\_\_) \_\_\_\_\_ Is it ok to leave a phone message? (please circle) No Yes

**IMPORTANT: E-mail is not a secure communication medium.**

**During an emergency, e-mail is NOT recommended as a method to contact me.** If you are having an emergency, you should dial 911. Your e-mail message may not be seen or responded to immediately. In addition, e-mails are not guaranteed as confidential.

**I will not use e-mail unless authorized to do so with your consent. I will only use e-mail with regard to appointments or changes in contact information.**

Please check one:

\_\_\_\_ I **DO** give permission to be contacted by email by E-MAIL: \_\_\_\_\_\_\_\_\_ I **DO NOT** give permission to be contacted by email.

*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 circle appropriate categories:**

Citizenship: United States Other \_\_\_\_\_

**School Information:**

School Name: \_\_\_\_\_ Major: \_\_\_\_\_

Class: Freshman Sophomore Junior Senior 5<sup>th</sup> Year Graduate Transfer Student

School Status: Full time Part time Continuing Education

**Employment Information:**

Employment: Full time Part time # of Hours/week \_\_\_\_\_

Employer: \_\_\_\_\_

Residence: With Family Alone Roommates Dorm Off-Campus Greek Other: \_\_\_\_\_

Referred by: Self Family Friend Doctor Counselor Advisor Administrator

Name/or Other \_\_\_\_\_

**Please describe yourself as fully as you feel comfortable:****How much reluctance to you have about coming in for therapy today?** Please circle one:

No reluctance at all Very little reluctance Some reluctance Quite a bit of reluctance Strong reluctance

**If more than one applies to you, please check all that apply:***Gender*

\_\_\_\_ Male

\_\_\_\_ Female

\_\_\_\_ Transgender

\_\_\_\_ MTF

\_\_\_\_ FTM

\_\_\_\_ Intersex

*Relationship Status*

\_\_\_\_ Single

\_\_\_\_ Married or Partnered

\_\_\_\_ Separated

\_\_\_\_ Divorced

\_\_\_\_ Widowed

\_\_\_\_ Other \_\_\_\_\_

*Sexual Orientation*

\_\_\_\_ Bi-Sexual

\_\_\_\_ Gay or Lesbian

\_\_\_\_ Heterosexual

\_\_\_\_ Questioning

*Ethnicity/Race*

\_\_\_\_ African-American

\_\_\_\_ Arab American

\_\_\_\_ Asian or \_\_\_\_ Pacific Islander

\_\_\_\_ Caucasian, European-American

\_\_\_\_ Chicano, Latino, Hispanic

\_\_\_\_ Native or \_\_\_\_ Alaskan Native

\_\_\_\_ Other \_\_\_\_\_

**Religious affiliation/Spirituality:****Do you identify as having a disability?** No Yes (please specify)

## PRESENTING COMPLAINT:

Why are you coming in to see me?

Please check all issues that currently concern you (write the number 1 and 2 next to the two most important topics):

- |  |  |
|--|--|
| <input type="checkbox"/> Depression                                | <input type="checkbox"/> Sexual Health Issues                    |
| <input type="checkbox"/> Bipolar (Manic -Depression)               | <input type="checkbox"/> Understanding Own Sexuality             |
| <input type="checkbox"/> Anxiety                                   | <input type="checkbox"/> coming-out process                      |
| <input type="checkbox"/> Alcohol Use                               | <input type="checkbox"/> sexual orientation                      |
| <input type="checkbox"/> Substance Use                             | <input type="checkbox"/> gender identity                         |
| <input type="checkbox"/> Eating /Body Image                        | <input type="checkbox"/> Adjusting to School/Work                |
| <input type="checkbox"/> Attention Deficit Disorder                | <input type="checkbox"/> Improved Relationships with:            |
| <input type="checkbox"/> Self-understanding                        | <input type="checkbox"/> Friends                                 |
| <input type="checkbox"/> Self-acceptance                           | <input type="checkbox"/> Partner                                 |
| <input type="checkbox"/> Self-care (hygiene, taking time for self) | <input type="checkbox"/> Family                                  |
| <input type="checkbox"/> Good Decision Making                      | <input type="checkbox"/> Issues of Racial/Ethnic Identity        |
| <input type="checkbox"/> Assertiveness                             | <input type="checkbox"/> Respecting Cultural Differences         |
| <input type="checkbox"/> Stress Management                         | <input type="checkbox"/> Understanding My Impact on Others       |
| <input type="checkbox"/> Clarification of Own Values               | <input type="checkbox"/> Decreasing Own Suicidal Thoughts        |
| <input type="checkbox"/> Grief                                     | <input type="checkbox"/> Eliminating/Reducing Unhealthy Behavior |
| <input type="checkbox"/> Working Through a Traumatic Event(s)      | <input type="checkbox"/> Academic/Work Problems                  |
| <input type="checkbox"/> Other (specify):                          |  |

## HISTORY 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 check all the following symptoms that you have experienced:

= Recent (within the last month)

= Past (one month ago or longer)

- |  |  |
|--|--|
| <input type="checkbox"/> <input type="radio"/> change in appetite                          | <input type="checkbox"/> <input type="radio"/> feelings of restlessness                        |
| <input type="checkbox"/> <input type="radio"/> significant weight gain/loss                | <input type="checkbox"/> <input type="radio"/> trembling or shaking                            |
| <input type="checkbox"/> <input type="radio"/> change in mood                              | <input type="checkbox"/> <input type="radio"/> accelerated heart rate                          |
| <input type="checkbox"/> <input type="radio"/> irritability                                | <input type="checkbox"/> <input type="radio"/> shortness of breath                             |
| <input type="checkbox"/> <input type="radio"/> feelings of worthlessness                   | <input type="checkbox"/> <input type="radio"/> sweating  |
| <input type="checkbox"/> <input type="radio"/> changes in sleeping patterns                | <input type="checkbox"/> <input type="radio"/> chest pain                                      |
| <input type="checkbox"/> <input type="radio"/> loss of energy                              | <input type="checkbox"/> <input type="radio"/> feelings of choking                             |
| <input type="checkbox"/> <input type="radio"/> loss of interest in activities              | <input type="checkbox"/> <input type="radio"/> nausea  |
| <input type="checkbox"/> <input type="radio"/> loss or decrease in sexual interest         | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of death                     |
| <input type="checkbox"/> <input type="radio"/> increase of energy                          | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of wanting to commit suicide |
| <input type="checkbox"/> <input type="radio"/> difficulty concentrating                    | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of harming others            |
| <input type="checkbox"/> <input type="radio"/> nightmares                                  | <input type="checkbox"/> <input type="radio"/> cutting or burning myself                       |
| <input type="checkbox"/> <input type="radio"/> substance abuse (alcohol or drugs)          | <input type="checkbox"/> <input type="radio"/> seeing things that others do not                |
| <input type="checkbox"/> <input type="radio"/> problems with attention, motivation, memory | <input type="checkbox"/> <input type="radio"/> hearing voices that others do not               |
| <input type="checkbox"/> <input type="radio"/> recurrent and excessive anxiety or worry    | <input type="checkbox"/> <input type="radio"/> paranoid thoughts                               |

**DESCRIBE YOUR CURRENT FUNCTIONING:**

<i>Currently, I am able to...</i>	n/a	Never	Rarely	Sometimes	Frequently	Always
attend work/classes						
concentrate on duties /tasks/assignments						
maintain employment						
maintain satisfying relationship w/ significant other						
maintain satisfying relationships w/ family members						
initiate & maintain satisfying social relationships w/ peers						
take care of my self & participate in social/recreational activities						
decide on plans for future						
demonstrate adequate coping skills, esp under increased stress						
seek assistance when stress and problems are not manageable						
decrease substance abuse and/or other high-risk behaviors						

GPA (if applicable): Current? \_\_\_\_\_ Last Semester? \_\_\_\_\_ High School (optional)? \_\_\_\_\_

Are you thinking about leaving your job or school? No Yes

Are you at risk for being of being fired from your job or expelled from school? No Yes

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

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

Describe your support systems (friends, family, spiritual or cultural groups, etc.): Are they in Boulder? No Yes

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

**PERTINENT PERSONAL/FAMILY HISTORY:** (Please fill in information about yourself and your family members)

	<i>Biological?</i>	<i>Age</i>	<i>Occupation</i>	<i>Mental Health Concerns</i>	<i>Physical Health Concerns</i>	<i>Medical Concerns</i>
<i>You</i>	n/a					
<i>Parent</i>	Y N					
<i>Parent</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Child M F</i>	Y N					
<i>Child M F</i>	Y N					
<i>Child M F</i>	Y N					
<i>Others</i>						

Are your parents married / separated / divorced / remarried?

If divorced, how old were you at that time?

Describe your relationship with each parent:

Describe your relationship(s) with your sibling(s):

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 (depression, anxiety, etc.)? No Yes – Please list:

Is there a history of alcoholism in your extended family? No Yes – Please list:

### MEDICAL HISTORY

<i>Have you had...</i>	<i>Recently (if yes, describe)</i>	<i>Past (if yes, describe)</i>
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?	N Y	N Y
known allergies to medications?	N Y	N Y
hospitalization for a medical condition?	N Y	N Y

List Current Medications (if different from above) \_\_\_\_\_

### PREVIOUS MENTAL HEALTH TREATMENT

Age	With Whom	How Long	Focus of Treatment	Helpful?	List Medications
				N Y	
				N Y	
				N Y	

Have you ever been hospitalized for mental health treatment? No Yes If yes, was it voluntary? No Yes

### SUICIDAL/HOMICIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS

<i>Have you ever had...</i>	<i>Current (if yes, describe)</i>	<i>Past (if yes, describe)</i>
thoughts of 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

Physical (e.g., car accidents, assault, abuse, head trauma)

Emotional (e.g., victim of crime, abuse, loss or death of relative / friend)

Sexual (e.g., sexual harassment, sexual assault)

**LEGAL HISTORY:** Have you ever been arrested or convicted of a legal violation?

**SEXUAL ACTIVITY:** Are you sexually active? No Yes

Do you use latex condoms or other safer sex techniques every time to prevent sexually transmitted diseases? No Yes

**SUBSTANCE USE HISTORY:** Please indicate your use of the following substances:

List	Current Use		Past Use	
	Frequency # of days of the week	Amount Per Day	Frequency # of days of the week	Amount of Use Per Day
Alcohol	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Other	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

**PLEASE DESCRIBE ANYTHING ELSE YOU WOULD LIKE TO TALK ABOUT:**

**PLEASE DESCRIBE YOUR GOALS FOR THERAPY:**